

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

DAVID BLISS,

Plaintiff,

vs.

BNSF RAILWAY COMPANY,

Defendant.

4:12CV3019

ORDER

IT IS ORDERED that the defendant's deposition objections, (Filing No. 190), are granted in part and denied in part as set forth in the attached transcripts.

May 16, 2014.

BY THE COURT:

s/ Cheryl R. Zwart
United States Magistrate Judge

DEPOSITION OF

DR. DANIEL RIPA



*Condensed Transcript and Concordance
Prepared By:*

LORI MCGOWAN, RDR, CCR, CRR
Certified Realtime Reporter

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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF NEBRASKA
3
4 DAVID BLISS, }
5 Plaintiff, } CASE NO. 4:12CV 3019
6 vs. } DEPOSITION TAKEN IN
7 BNSF RAILWAY COMPANY, } BEHALF OF PLAINTIFF
8 Defendant. }

9
10
11
12 DEPOSITION OF: DR. DANIEL R. RIPA
13 DATE: February 24, 2014
14 TIME: 7:01 a.m.
15 PLACE: 575 South 70th Street, Suite 200,
16 Lincoln, Nebraska
17
18
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20
21
22
23
24
25

1 I-N-D-E-X
2 WITNESS Direct Cross Redirect Recross
3 DR. DANIEL RIPA 4 13 -- --

4 EXHIBITS Marked Offered
5 78C. 10-4-12 Opinion Letter to
6 Luers from Ripa 4 --
7
8 78D Curriculum Vitae 4 --
9
10
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1 A P P E A R A N C E S.
2 APPEARING FOR THE PLAINTIFF:
3 (Appearing Telephonically)
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11 APPEARING FOR THE DEFENDANT:
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1 S-T-I-P-U-L-A-T-I-O-N-S
2 It is hereby stipulated and agreed by and
3 between the parties that;
4 Notice of taking said deposition is
5 waived; notice of delivery of said deposition
6 is waived.
7 Presence of the witness during the
8 transcription of the stenotype notes is waived.
9 Taken pursuant to the Federal Rules of
10 Civil Procedure.
11 (Exhibit Nos. 78C and 78D
12 marked for identification.)
13 DR. DANIEL R. RIPA,
14 Of lawful age, being first duly cautioned and
15 solemnly sworn as hereinafter certified, was
16 examined and testified as follows:
17 DIRECT EXAMINATION
18 BY MR. McMAHON:
19 Q. Doctor, could you please state your name
20 for the jury.
21 A. Daniel Ray Ripa.
22 Q. And what's your profession or
23 occupation?
24 A. I'm an orthopedic surgeon, a physician,
25 orthopedic surgeon.

5

1 Q. And showing you what's been marked as
2 78D, exhibit, is this a true and accurate copy
3 of your curriculum vitae?

4 A. It is, correct.

5 Q. Would you tell the jury a little bit
6 about your educational background and training
7 to be an orthopedic surgeon?

8 A. Well, I went to the University of
9 Nebraska Medical Center for my medical
10 doctorate degree.

11 And then did a flexible internship and
12 residency at Scott & White Memorial Hospital in
13 Temple, Texas.

14 And after that, did a one-year spine
15 fellowship that was split between New Orleans
16 and Chicago, the latter part at Northwestern in
17 Chicago on the regional spinal cord injury
18 unit.

19 Q. And are you in private practice?

20 A. Correct.

21 Q. And could you give the jury an idea
22 about the nature of your practice, what type of
23 conditions you treat, how many surgeries or
24 patients you treat on a weekly or monthly
25 basis, that type of thing?

6

1 A. Well, we're -- or I am a member of a 12-
2 or 13-man orthopedic group. And we see
3 patients all week long and do surgery all week
4 long, a mixture of about half clinic, half
5 surgery.

6 And I treat a variety of neck and low
7 back disorders, scoliosis, fractures of the
8 spine.

9 I also do a fair amount of work in
10 artificial joint replacement.

11 Q. Okay. And do you regularly attend
12 medical conferences or continuing medical
13 education to keep up on the issues in your
14 field?

15 A. I do.

16 Q. Okay. And are you published anywhere
17 that we may have heard of in terms of articles
18 or that type of peer-review journals?

19 A. Not for a long time. Did some back in
20 the fellowship period. But not since then.

21 Q. All right. Doctor, at BNSF's request,
22 did you perform a medical records review for
23 this case, for Mr. Bliss?

24 A. That is correct.

25 Q. All right. And do you recall what

7

1 materials that you reviewed in helping to
2 formulate your opinions and conclusions in this
3 matter?

4 A. Well, I looked at several MRI scans, a
5 variety of medical records, some therapy notes,
6 some evaluations that the patient had had for
7 their fitness for work and those sorts of
8 things.

9 Q. All right. And were these medical
10 records -- they also predated the February
11 incident that centralized this case; correct?

12 A. Yes. Some portions of them did.

13 Q. Okay. And are these the type of
14 materials, documents that you and other
15 orthopedic surgeons typically rely upon to
16 assist them in formulating their opinions and
17 conclusions as to a person's current medical
18 condition?

19 A. Yes.

20 Q. And did you rely upon this information
21 as well as your background and training as an
22 orthopedic surgeon in formulating your own
23 opinions and conclusions in this matter?

24 A. Yes.

25 Q. All right. And if we look at Exhibit

8

1 78C.

2 A. I have it.

3 Q. Okay. There's listed here, I believe,
4 seven numbered paragraphs. Do you see what I'm
5 referring to?

6 A. Yes.

7 Q. All right. Are those the opinions and
8 conclusions that you reached in this matter as
9 far as relates to Mr. Bliss?

10 A. Yes.

11 Q. All right. And if we could, let's just
12 go one by one through them. And we'll identify
13 them. And if you could, just explain the basis
14 for those opinions. All right?

15 A. Okay.

16 Q. All right. So No. 1, could you read it,
17 please?

18 A. These are responses to the attorney that
19 I believe represented the railroad previously.

20 The first response, I put, "Dr. Noble's
21 release for Mr. Bliss to return to work without
22 restrictions as per the request of Mr. Bliss in
23 July 2010 was too liberal for someone with
24 Mr. Bliss' degenerative spine condition."

25 Q. Okay. What's the basis for that

BNSF
objects to
the
testimony as
hearsay
without an
exception
and as not
relevant.
Fed. R.
Evid. 402,
403, 801,
and 802.
Ruling:
Overruled

9
1 opinion, Doctor?
2 **A. Well, the patient did have some fairly**
3 **significant abnormalities chronically in his**
4 **low back. And in general, we would tend to**
5 **imply or put upon the patient at least some**
6 **degree of general restriction against excessive**
7 **lifting or activities that might be considered**
8 **likely to cause some degree of difficulty with**
9 **his back in the future.**
10 **Q. Okay. Do you have any idea what those**
11 **types of restrictions would be?**
12 **A. Well, our more generic restriction for**
13 **someone with a low back condition is to try and**
14 **avoid lifting in excess of 50 pounds at any**
15 **time and, also, to keep repetitive lifting at**
16 **or below about 25 pounds.**
17 **Other restrictions might be a bit more**
18 **specific to the particular work activities.**
19 **Q. Okay. Were you asked to look at the**
20 **particular work activities in this case or no?**
21 **A. Well, I don't recall a specific -- and I**
22 **stand corrected.**
23 **I don't recall a specific delineation of**
24 **the work activities in this person's**
25 **employment.**

10
1 Q. Okay. And then moving on to No. 2, I
2 guess it's pretty self-explanatory, but just
3 briefly go over the basis for opinion No. 2.
4 **A. Well, this opinion was, "Mr. Bliss was**
5 **clearly suffering from degenerative disk**
6 **disease, particularly at the L3 slash 4, L4**
7 **slash 5 and L5 slash S1 levels prior to**
8 **February 3rd, 2011."**
9 Q. And the basis for that, was that just
10 the prior medical records and the diagnostic
11 films that you reviewed?
12 **A. Correct. Specifically the MRI scan.**
13 Q. Okay. And No. 3, could you read that
14 and explain the basis for your opinion there?
15 **A. This response was, "The change in**
16 **Mr. Bliss' back condition between the MRI of**
17 **April 27th, 2010, and March 18th, 2011, showed**
18 **an increase in degenerative facet joints,**
19 **foraminal narrowing and increased degenerative**
20 **bone marrow at L4 slash 5 and L5 slash S1."**
21 Q. Okay. What -- what -- what does that
22 mean, and what's the basis for that opinion,
23 sir?
24 **A. Well, the basis for that opinion is**
25 **looking at the two MRIs. One was prior to the**

11
1 incident in question. The other was shortly
2 after it.
3 And basically the MRI scan showed an
4 increase in these degenerative changes rather
5 than any clearcut evidence of an acute, sudden
6 abnormality such as a broken bone or ruptured
7 disk or something of that nature.
8 Q. Okay. And then No. 4?
9 **A. No. 4, "The changes noted in the above**
10 **response, paragraph No. 3, could be the result**
11 **of the natural progression of a degenerative**
12 **spinal condition."**
13 Q. All right. Could the changes that
14 appear in No. 3, could it be in part due to the
15 February 3rd, 2009, incident?
16 **A. Well, I would have to say that I did not**
17 **see any sudden abnormality such as a ruptured**
18 **disk, compression fracture or hyperintense zone**
19 **in the spine that would indicate that there was**
20 **some, you know, acute traumatic change.**
21 Q. Okay.
22 **A. So I would say that's less likely.**
23 Q. Okay. And then No. 5?
24 **A. "The Functional Capacity Evaluation of**
25 **June 30th, 2011, appeared to be a valid**

12
1 **Functional Capacity Evaluation so as to reflect**
2 **Mr. Bliss' physical capabilities as of that**
3 **date."**
4 Q. All right. And then No. 6?
5 **A. No. 6, I responded, "Because of multiple**
6 **back surgeries and continued natural**
7 **progression of his degenerative spine condition**
8 **and past history of knee and shoulder joint**
9 **degeneration and surgery, it would be**
10 **reasonable to restrict Mr. Bliss currently to**
11 **lifting no more than 20 pounds and on**
12 **occasion -- and only occasional bending,**
13 **stooping and crawling."**
14 Q. Okay. And what's the basis for that
15 opinion?
16 **A. Well, that was basically looking at the**
17 **Functional Capacity Evaluation and the**
18 **reflection of his physical abilities and**
19 **basically endorsing that those recommendations**
20 **were reasonable, based upon the medical record.**
21 Q. Okay. And lastly, Doctor, No. 7 there.
22 **A. I answered, "From a review of Mr. Bliss'**
23 **medical history, MRIs and degenerative**
24 **condition, it was likely that Mr. Bliss --**
25 **excuse me, Mr. Bliss' back would have continued**

1 to degenerate after 2004, regardless of his
2 work environment."

3 Q. All right. And the basis for that
4 opinion is what, sir?

5 A. Well, the natural progression of
6 degenerative disk disease creates the
7 appearance of the MRI scan that we saw. And
8 essentially no matter what you're doing, that
9 type of change in the spine does continue to
10 occur over time.

11 Q. All right. And do you hold these
12 opinions to a reasonable degree of orthopedic
13 surgery, Doctor?

14 A. I -- reasonable degree of medical
15 certainty, yes.

16 Q. Yes. Okay.

17 MR. McMAHON: Thank you, Doctor,
18 that's all I have.

19 CROSS-EXAMINATION

20 BY MR. SATTLER:

21 Q. Dr. Noble --

22 A. Dr. Ripa.

23 Q. I'm sorry. Dr. Ripa. I'm sorry. With
24 respect to the -- some of the medical records
25 that you had available to you, that would have

1 included an exhibit that had been marked
2 previously as Exhibit No. 58, which is this
3 statement of job awareness and general duties
4 of a carman. This was dated and signed by
5 Dr. Noble back in August of 2010. You would
6 have had that available to you, would you not?

7 A. Yes. I believe looking now, that that
8 was included in Dr. Noble's records rather than
9 a specific entry in the files that I have.

10 Q. Right. And this would have covered
11 basic activities, anticipated or expected, as
12 general job duties of a carman?

13 A. Yes.

14 Q. Now, with respect to this broad category
15 of degenerative disk disease, could you explain
16 to the ladies and gentlemen of the jury what
17 degenerative disk disease is?

18 There's been terms thrown around, like,
19 spondylolisthesis, lumbar spondylosis and then
20 this disk degeneration. Could you explain what
21 these diseases are?

22 A. Well, certainly. Our natural tendency
23 to age takes its toll on our spine. Generally
24 most everyone is subject to losing moisture in
25 their disk spaces. The disk spaces are the

1 cushions between the vertebrae.

2 As this cushion material loses moisture,
3 it becomes less elastic, less resilient to
4 resisting shock. And our spine tends to settle
5 somewhat. So that's why we naturally get a
6 little shorter as we get older.

7 A degenerative disk does not have as
8 good a support between the vertebrae, so it
9 places more load or demand upon the little
10 joints in the back of the spine.

11 And as these joints absorb more load and
12 the cartilages ages in the joints, then those
13 joints wear out.

14 So the term spondylosis, which is sort
15 of a medical term for degenerative change or
16 wear and tear change in the spine, that is a
17 fairly accurate descriptor of what we saw on
18 the MRI scans of the patient.

19 Disk degeneration, another way of
20 describing it, some people will call it
21 osteoarthritis of the spine, which is fairly
22 accurate.

23 You mentioned a word spondylolisthesis.
24 Spondylolisthesis is a term where one vertebra
25 shifts slightly forward on the other. That is

1 a situation where if the disk is degenerated
2 and the facet joints wear out, then there may
3 be some subtle shifting in the spine where
4 either the vertebra goes forward or to the
5 side.

6 And that is a term that was, I believe,
7 mentioned once regarding the spine in this
8 patient between lumbar 4 and lumbar 5.

9 Q. With respect to the imaging studies that
10 were made available to you during your review,
11 you had the benefit of seeing MRIs dating back
12 to as early as 2002 and then moving up through
13 and past the time of the February 2011
14 timeframe; isn't that correct?

15 A. That is correct.

16 Q. So you would have had an opportunity to
17 see the changes that would have occurred as a
18 result of this disease process that you've
19 described?

20 A. That is correct.

21 Q. There is reference in the various MRI
22 studies to facet hypertrophy. Can you explain
23 to the ladies and gentlemen of the jury what
24 the facets are and what that's really
25 describing?

17

1 **A.** The facet joints are the little
2 connectors between each vertebra. So there is
3 a left and a right joint that connects one
4 vertebra to the other.

5 These are small little joints. They
6 overlap each other, about the size of a
7 fingernail. And as these joints wear out, the
8 cartilage space decreases or thins. And then
9 the patient's joints start to enlarge or
10 thicken.

11 The most -- the most easily understood
12 example is someone's knuckles. If you have a
13 grandmother that has a lot of arthritis in her
14 hands, you'll see that her knuckles have
15 enlarged. And that's the same thing that's
16 occurring in the spine. We just can't see it
17 underneath the muscles.

18 The spinal joints enlarge and thicken
19 and get irregular. And sometimes as those
20 joints enlarge, then they pinch the nerve or
21 narrow the openings for the nerves.

22 Q. And this facet joint deterioration,
23 based upon the MRI studies that you were able
24 to view, showed this degenerative process over
25 time?

18

1 **A.** That is correct.

2 **Q.** Doctor, you were asked some questions by
3 counsel for plaintiff related to what type of
4 generic restrictions that you would apply in
5 this discussion of this first opinion related
6 to Dr. Noble's release to return to work
7 without restrictions.

8 I wanted to ask you, you're familiar
9 with -- generally with the process of how
10 employers obtain return to work restrictions
11 from treating physicians? This is something
12 that's common in your practice; is that true?

13 **A.** That is correct.

14 **Q.** When you say that the return to work
15 without restrictions by Dr. Noble was too
16 liberal, do you believe that it was reasonable
17 and prudent for an employer in BNSF's position
18 to reasonably rely upon work restrictions
19 established by a treating physician?

20 **A.** Yes, I do.

21 **Q.** In this case, do you believe that it was
22 reasonable and prudent for the BNSF Railway
23 Company to rely upon this return to work
24 restriction or work -- return to work without
25 restriction that was issued by Dr. Noble?

19

1 **A.** Yes.

2 MR. SATTLER: Those are all the
3 questions I have, Doctor. Thank you.

4 MR. McMAHON: Nothing further.
5 Thank you, Dr. Ripa, for your time this
6 morning.

7 THE WITNESS: I will waive the
8 right to read this.

9 (Deposition concluded at 7:19 a.m.)
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1 C-E-R-T-I-F-I-C-A-T-E

2 STATE OF NEBRASKA)

: ss.

3 COUNTY OF LANCASTER)

4 I, Lori J. McGowan, General Notary Public
5 in and for the State of Nebraska and Registered
6 Professional Reporter, hereby certify that DR.
7 DANIEL RIPA was by me duly sworn to testify the
8 truth, the whole truth and nothing but the
9 truth, that the deposition by him as above set
10 forth was reduced to writing by me.

11 That the within and foregoing deposition
12 was taken by me at the time and place herein
13 specified and in accordance with the within
14 stipulations; the reading and signing of the
15 deposition having been waived.

16 That the foregoing deposition is a true
17 and accurate reflection of the proceedings
18 taken in the above case.

19 That I am not counsel, attorney, or
20 relative of either party or otherwise
21 interested in the event of this suit.

22 IN TESTIMONY WHEREOF, I place my hand and
23 notarial seal this 24th day of February, 2014.
24
25

<p>1</p> <p>1 [1] - 8:16 10-4-12 [1] - 3:6 12 [1] - 6:1 13 [1] - 3:3 13-man [1] - 6:2 18th [1] - 10:17</p>	<p>68508 [1] - 2:10</p> <p>7</p> <p>7 [1] - 12:21 701 [1] - 2:9 70th [1] - 1:15 78C [3] - 3:6, 4:11, 8:1 78D [3] - 3:8, 4:11, 5:2 7:01 [1] - 1:14 7:19 [1] - 19:9</p>	<p>August [1] - 14:5 available [3] - 13:25, 14:6, 16:10 avoid [1] - 9:14 awareness [1] - 14:3</p>	<p>14:14 cautioned [1] - 4:14 Center [1] - 5:9 centraled [1] - 7:11 certainly [1] - 14:22 certainty [1] - 13:15 CERTIFICATE [1] - 20:1 certified [1] - 4:15 certify [1] - 20:6 change [5] - 10:15, 11:20, 13:9, 15:15, 15:16 changes [4] - 11:4, 11:9, 11:13, 16:17 Chicago [3] - 2:5, 5:16, 5:17 chronically [1] - 9:3 Civil [1] - 4:10 clearcut [1] - 11:5 clearly [1] - 10:5 clinic [1] - 6:4 common [1] - 18:12 COMPANY [1] - 1:7 Company [1] - 18:23 compression [1] - 11:18 concluded [1] - 19:9 conclusions [4] - 7:2, 7:17, 7:23, 8:8 condition [7] - 7:18, 8:24, 9:13, 10:16, 11:12, 12:7, 12:24 conditions [1] - 5:23 conferences [1] - 6:12 connectors [1] - 17:2 connects [1] - 17:3 considered [1] - 9:7 continue [1] - 13:9 continued [2] - 12:6, 12:25 continuing [1] - 6:12 copy [1] - 5:2 cord [1] - 5:17 correct [10] - 5:4, 5:20, 6:24, 7:11, 10:12, 16:14, 16:15, 16:20, 18:1, 18:13 corrected [1] -</p>	<p>9:22 counsel [2] - 18:3, 20:19 COUNTY [1] - 20:3 COURT [1] - 1:1 covered [1] - 14:10 crawling [1] - 12:13 creates [1] - 13:6 Cross [1] - 3:2 CROSS [1] - 13:19 CROSS- EXAMINATION [1] - 13:19 current [1] - 7:17 Curriculum [1] - 3:8 curriculum [1] - 5:3 cushion [1] - 15:2 cushions [1] - 15:1</p>	<p>DEPOSITION [2] - 1 1:6, 1:12 described [1] - 16:19 describing [2] - 15:20, 16:25 descriptor [1] - 15:17 deterioration [1] - 17:22 diagnostic [1] - 10:10 difficulty [1] - 9:8 Direct [1] - 3:2 DIRECT [1] - 4:17 discussion [1] - 18:5 disease [5] - 10:6, 13:6, 14:15, 14:17, 16:18 diseases [1] - 14:21 disk [12] - 10:5, 11:7, 11:18, 13:6, 14:15, 14:17, 14:20, 14:25, 15:7, 15:19, 16:1 disorders [1] - 6:7 DISTRICT [2] - 1:1, 1:2 Doctor [5] - 9:1, 12:21, 13:13, 13:17, 19:3 doctor [3] - 4:19, 6:21, 18:2 doctorate [1] - 5:10 documents [1] - 7:14 DR [4] - 1:12, 3:3, 4:13, 20:6 Dr [10] - 8:20, 13:21, 13:22, 13:23, 14:5, 14:8, 18:6, 18:15, 18:25, 19:5 due [1] - 11:14 duly [2] - 4:14, 20:7 during [2] - 4:7, 16:10 duties [2] - 14:3, 14:12</p>
<p>2</p> <p>2 [2] - 10:1, 10:3 20 [1] - 12:11 200 [2] - 1:15, 2:5 2002 [1] - 16:12 2004 [1] - 13:1 2009 [1] - 11:15 2010 [3] - 8:23, 10:17, 14:5 2011 [4] - 10:8, 10:17, 11:25, 16:13 2014 [2] - 1:13, 20:23 24 [1] - 1:13 24th [1] - 20:23 25 [1] - 9:16 27th [1] - 10:17</p>	<p>A</p> <p>a.m. [2] - 1:14, 19:9 abilities [1] - 12:18 able [1] - 17:23 abnormalities [1] - 9:3 abnormality [2] - 11:6, 11:17 absorb [1] - 15:11 accordance [1] - 20:13 accurate [4] - 5:2, 15:17, 15:22, 20:17 activities [5] - 9:7, 9:18, 9:20, 9:24, 14:11 acute [2] - 11:5, 11:20 age [2] - 4:14, 14:23 ages [1] - 15:12 agreed [1] - 4:2 amount [1] - 6:9 answered [1] - 12:22 anticipated [1] - 14:11 appear [1] - 11:14 appearance [1] - 13:7 appeared [1] - 11:25 APPEARING [2] - 2:2, 2:7 Appearing [1] - 2:2 apply [1] - 18:4 April [1] - 10:17 arthritis [1] - 17:13 articles [1] - 6:17 artificial [1] - 6:10 assist [1] - 7:16 attend [1] - 6:11 attorney [2] - 8:18, 20:19 Attorney [2] - 2:4, 2:8</p>	<p>B</p> <p>background [2] - 5:6, 7:21 based [2] - 12:20, 17:23 basic [1] - 14:11 basis [10] - 5:25, 8:13, 8:25, 10:3, 10:9, 10:14, 10:22, 10:24, 12:14, 13:3 becomes [1] - 15:3 BEHALF [1] - 1:7 below [1] - 9:16 bending [1] - 12:12 benefit [1] - 16:11 between [7] - 4:3, 5:15, 10:16, 15:1, 15:8, 16:8, 17:2 bit [2] - 5:5, 9:17 BLISS [1] - 1:4 Bliss [7] - 6:23, 8:9, 8:21, 8:22, 10:4, 12:10, 12:24 Bliss' [5] - 8:24, 10:16, 12:2, 12:22, 12:25 BNSF [2] - 1:7, 18:22 BNSF's [2] - 6:21, 18:17 bone [2] - 10:20, 11:6 briefly [1] - 10:3 broad [1] - 14:14 broken [1] - 11:6 BY [2] - 4:18, 13:20</p>	<p>C</p> <p>capabilities [1] - 12:2 Capacity [3] - 11:24, 12:1, 12:17 carman [2] - 14:4, 14:12 cartilage [1] - 17:8 cartilages [1] - 15:12 case [5] - 6:23, 7:11, 9:20, 18:21, 20:18 CASE [1] - 1:5 category [1] -</p>	<p>D</p> <p>Daniel [1] - 4:21 DANIEL [4] - 1:12, 3:3, 4:13, 20:7 date [1] - 12:3 DATE [1] - 1:13 dated [1] - 14:4 dating [1] - 16:11 DAVID [1] - 1:4 Dearborn [1] - 2:4 decreases [1] - 17:8 Defendant [1] - 1:8 DEFENDANT [1] - 2:7 degenerate [1] - 13:1 degenerated [1] - 16:1 degeneration [3] - 12:9, 14:20, 15:19 degenerative [14] - 8:24, 10:5, 10:18, 10:19, 11:4, 11:11, 12:7, 12:23, 13:6, 14:15, 14:17, 15:7, 15:15, 17:24 degree [5] - 5:10, 9:6, 9:8, 13:12, 13:14 delineation [1] - 9:23 delivery [1] - 4:5 demand [1] - 15:9 Deposition [1] - 19:9 deposition [6] - 4:4, 4:5, 20:9, 20:11, 20:15, 20:16</p>	<p>E</p> <p>early [1] - 16:12 easily [1] - 17:11 education [1] - 6:13 educational [1] - 5:6 either [2] - 16:4,</p>
<p>3</p> <p>3 [3] - 10:13, 11:10, 11:14 301 [1] - 2:9 3019 [1] - 1:5 30th [1] - 11:25 3rd [2] - 10:8, 11:15</p>					
<p>4</p> <p>4 [7] - 3:3, 3:6, 3:8, 10:6, 11:8, 11:9, 16:8 4:12CV [1] - 1:5</p>					
<p>5</p> <p>5 [4] - 10:7, 10:20, 11:23, 16:8 50 [1] - 9:14 542 [1] - 2:4 575 [1] - 1:15 58 [1] - 14:2</p>					
<p>6</p> <p>6 [2] - 12:4, 12:5 60605 [1] - 2:5</p>					

20:20 elastic [1] - 15:3 employer [1] - 18:17 employers [1] - 18:10 employment [1] - 9:25 endorsing [1] - 12:19 enlarge [3] - 17:9, 17:18, 17:20 enlarged [1] - 17:15 entry [1] - 14:9 environment [1] - 13:2 essentially [1] - 13:8 established [1] - 18:19 Evaluation [3] - 11:24, 12:1, 12:17 evaluations [1] - 7:6 event [1] - 20:21 evidence [1] - 11:5 EXAMINATION [2] - 4:17, 13:19 examined [1] - 4:16 example [1] - 17:12 excess [1] - 9:14 excessive [1] - 9:6 excuse [1] - 12:25 exhibit [2] - 5:2, 14:1 Exhibit [3] - 4:11, 7:25, 14:2 EXHIBITS [1] - 3:5 expected [1] - 14:11 explain [5] - 8:13, 10:14, 14:15, 14:20, 16:22 explanatory [1] - 10:2	16:13, 20:23 Federal [1] - 4:9 fellowship [2] - 5:15, 6:20 field [1] - 6:14 files [1] - 14:9 films [1] - 10:11 finger nail [1] - 17:7 first [3] - 4:14, 8:20, 18:5 fitness [1] - 7:7 flexible [1] - 5:11 follows [1] - 4:16 FOR [3] - 1:2, 2:2, 2:7 foraminal [1] - 10:19 foregoing [2] - 20:11, 20:16 formulate [1] - 7:2 formulating [2] - 7:16, 7:22 forth [1] - 20:10 forward [2] - 15:25, 16:4 fracture [1] - 11:18 fractures [1] - 6:7 Functional [3] - 11:24, 12:1, 12:17 future [1] - 9:9	hold [1] - 13:11 Hospital [1] - 5:12 hyperintense [1] - 11:18 hypertrophy [1] - 16:22	knee [1] - 12:8 knuckles [2] - 17:12, 17:14	20:4 McMahon [4] - 2:3, 4:18, 13:17, 19:4 mean [1] - 10:22 Medical [1] - 5:9 medical [13] - 5:9, 6:12, 6:22, 7:5, 7:9, 7:17, 10:10, 12:20, 12:23, 13:14, 13:24, 15:15 member [1] - 6:1 Memorial [1] - 5:12 mentioned [2] - 15:23, 16:7 might [2] - 9:7, 9:17 mixture [1] - 6:4 moisture [2] - 14:24, 15:2 monthly [1] - 5:24 morning [1] - 19:6 most [3] - 14:24, 17:11 moving [2] - 10:1, 16:12 MR [5] - 4:18, 13:17, 13:20, 19:2, 19:4 MRI [8] - 7:4, 10:12, 10:16, 11:3, 13:7, 15:18, 16:21, 17:23 MRIs [3] - 10:25, 12:23, 16:11 multiple [1] - 12:5 muscles [1] - 17:17	14:8, 18:6 Northwestern [1] - 5:16 Nos [1] - 4:11 notarial [1] - 20:23 Notary [1] - 20:4 noted [1] - 11:9 notes [2] - 4:8, 7:5 nothing [2] - 19:4, 20:8 Notice [1] - 4:4 notice [1] - 4:5 numbered [1] - 8:4
	G	I	L	O	
	General [1] - 20:4 general [4] - 9:4, 9:6, 14:3, 14:12 generally [2] - 14:23, 18:9 generic [2] - 9:12, 18:4 gentlemen [2] - 14:16, 16:23 grandmother [1] - 17:13 group [1] - 6:2 guess [1] - 10:2	idea [2] - 5:21, 9:10 identification [1] - 4:12 identify [1] - 8:12 IL [1] - 2:5 imaging [1] - 16:9 imply [1] - 9:5 IN [3] - 1:1, 1:6, 20:22 incident [3] - 7:11, 11:1, 11:15 included [2] - 14:1, 14:8 increase [2] - 10:18, 11:4 increased [1] - 10:19 INDEX [1] - 3:1 indicate [1] - 11:19 information [1] - 7:20 injury [1] - 5:17 interested [1] - 20:21 internship [1] - 5:11 irregular [1] - 17:19 issued [1] - 18:25 issues [1] - 6:13	L3 [1] - 10:6 L4 [2] - 10:6, 10:20 L5 [2] - 10:7, 10:20 ladies [2] - 14:16, 16:23 LANCASTER [1] - 20:3 lastly [1] - 12:21 latter [1] - 5:16 Law [2] - 2:4, 2:8 lawful [1] - 4:14 least [1] - 9:5 left [1] - 17:3 less [3] - 11:22, 15:3 Letter [1] - 3:6 levels [1] - 10:7 liberal [2] - 8:23, 18:16 lifting [4] - 9:7, 9:14, 9:15, 12:11 likely [3] - 9:8, 11:22, 12:24 Lincoln [2] - 1:16, 2:10 listed [1] - 8:3 load [2] - 15:9, 15:11 look [2] - 7:25, 9:19 looked [1] - 7:4 looking [3] - 10:25, 12:16, 14:7 Lori [1] - 20:4 loses [1] - 15:2 losing [1] - 14:24 low [3] - 6:6, 9:4, 9:13 Luers [1] - 3:6 lumbar [3] - 14:19, 16:8	name [1] - 4:19 narrow [1] - 17:21 narrowing [1] - 10:19 natural [4] - 11:11, 12:6, 13:5, 14:22 naturally [1] - 15:5 nature [2] - 5:22, 11:7 NE [1] - 2:10 NEBRASKA [2] - 1:2, 20:2 Nebraska [3] - 1:16, 5:9, 20:5 neck [1] - 6:6 nerve [1] - 17:20 nerves [1] - 17:21 New [1] - 5:15 NO [1] - 1:5 Noble [4] - 13:21, 14:5, 18:15, 18:25 Noble's [3] - 8:20,	obtain [1] - 18:10 occasion [1] - 12:12 occasional [1] - 12:12 occupation [1] - 4:23 occur [1] - 13:10 occurred [1] - 16:17 occurring [1] - 17:16 OF [5] - 1:2, 1:7, 1:12, 20:2, 20:3 Offered [1] - 3:5 older [1] - 15:6 once [1] - 16:7 one [6] - 5:14, 8:12, 10:25, 15:24, 17:3 one-year [1] - 5:14 openings [1] - 17:21 Opinion [1] - 3:6 opinion [9] - 9:1, 10:3, 10:4, 10:14, 10:22, 10:24, 12:15, 13:4, 18:5 opinions [6] - 7:2, 7:16, 7:23, 8:7, 8:14, 13:12 opportunity [1] - 16:16 Orleans [1] - 5:15 orthopedic [7] - 4:24, 4:25, 5:7, 6:2, 7:15, 7:22, 13:12 osteoarthritis [1] - 15:21 otherwise [1] - 20:20 overlap [1] - 17:6 own [1] - 7:22
F	H	J	M	N	
facet [5] - 10:18, 16:2, 16:22, 17:1, 17:22 facets [1] - 16:24 fair [1] - 6:9 fairly [3] - 9:2, 15:17, 15:21 familiar [1] - 18:8 far [1] - 8:9 February [6] - 1:13, 7:10, 10:8, 11:15,	half [2] - 6:4 hand [1] - 20:22 hands [1] - 17:14 heard [1] - 6:17 helping [1] - 7:1 hereby [2] - 4:2, 20:6 herein [1] - 20:12 hereinafter [1] - 4:15 history [2] - 12:8, 12:23	job [2] - 14:3, 14:12 joint [4] - 6:10, 12:8, 17:3, 17:22 joints [12] - 10:18, 15:10, 15:11, 15:12, 15:13, 16:2, 17:1, 17:5, 17:7, 17:9, 17:18, 17:20 journals [1] - 6:18 July [1] - 8:23 June [1] - 11:25 jury [5] - 4:20, 5:5, 5:21, 14:16, 16:23	March [1] - 10:17 Marked [1] - 3:5 marked [3] - 4:12, 5:1, 14:1 marrow [1] - 10:20 material [1] - 15:2 materials [2] - 7:1, 7:14 matter [4] - 7:3, 7:23, 8:8, 13:8 McGowan [1] -		
		K			
		keep [2] - 6:13, 9:15			

<p>P</p> <p>paragraph [1] - 11:10</p> <p>paragraphs [1] - 8:4</p> <p>part [2] - 5:16, 11:14</p> <p>particular [2] - 9:18, 9:20</p> <p>particularly [1] - 10:6</p> <p>parties [1] - 4:3</p> <p>party [1] - 20:20</p> <p>past [2] - 12:8, 16:13</p> <p>patient [5] - 7:6, 9:2, 9:5, 15:18, 16:8</p> <p>patient's [1] - 17:9</p> <p>patients [2] - 5:24, 6:3</p> <p>peer [1] - 6:18</p> <p>peer-review [1] - 6:18</p> <p>people [1] - 15:20</p> <p>per [1] - 8:22</p> <p>perform [1] - 6:22</p> <p>period [1] - 6:20</p> <p>person's [2] - 7:17, 9:24</p> <p>physical [2] - 12:2, 12:18</p> <p>physician [2] - 4:24, 18:19</p> <p>physicians [1] - 18:11</p> <p>pinch [1] - 17:20</p> <p>PLACE [1] - 1:15</p> <p>place [2] - 20:12, 20:22</p> <p>places [1] - 15:9</p> <p>plaintiff [1] - 18:3</p> <p>Plaintiff [1] - 1:5</p> <p>PLAINTIFF [2] - 1:7, 2:2</p> <p>portions [1] - 7:12</p> <p>position [1] - 18:17</p> <p>pounds [3] - 9:14, 9:16, 12:11</p> <p>practice [3] - 5:19, 5:22, 18:12</p> <p>predated [1] - 7:10</p> <p>Presence [1] - 4:7</p> <p>pretty [1] - 10:2</p> <p>previously [2] - 8:19, 14:2</p> <p>private [1] - 5:19</p> <p>Procedure [1] - 4:10</p> <p>proceedings [1] - 20:17</p> <p>process [3] -</p>	<p>16:18, 17:24, 18:9</p> <p>profession [1] - 4:22</p> <p>Professional [1] - 20:6</p> <p>progression [3] - 11:11, 12:7, 13:5</p> <p>prudent [2] - 18:17, 18:22</p> <p>Public [1] - 20:4</p> <p>published [1] - 6:16</p> <p>pursuant [1] - 4:9</p> <p>put [2] - 8:20, 9:5</p> <p>Q</p> <p>questions [2] - 18:2, 19:3</p> <p>R</p> <p>railroad [1] - 8:19</p> <p>RAILWAY [1] - 1:7</p> <p>Railway [1] - 18:22</p> <p>rather [2] - 11:4, 14:8</p> <p>Ray [1] - 4:21</p> <p>reached [1] - 8:8</p> <p>read [3] - 8:16, 10:13, 19:8</p> <p>reading [1] - 20:14</p> <p>really [1] - 16:24</p> <p>reasonable [6] - 12:10, 12:20, 13:12, 13:14, 18:16, 18:22</p> <p>reasonably [1] - 18:18</p> <p>recommendation [1] - 12:19</p> <p>record [1] - 12:20</p> <p>records [6] - 6:22, 7:5, 7:10, 10:10, 13:24, 14:8</p> <p>Recross [1] - 3:2</p> <p>Redirect [1] - 3:2</p> <p>reduced [1] - 20:10</p> <p>reference [1] - 16:21</p> <p>referring [1] - 8:5</p> <p>reflect [1] - 12:1</p> <p>reflection [2] - 12:18, 20:17</p> <p>regarding [1] - 16:7</p> <p>regardless [1] - 13:1</p> <p>regional [1] - 5:17</p> <p>Registered [1] - 20:5</p> <p>regularly [1] - 6:11</p>	<p>related [2] - 18:3, 18:5</p> <p>relates [1] - 8:9</p> <p>relative [1] - 20:20</p> <p>release [2] - 8:21, 18:6</p> <p>rely [4] - 7:15, 7:20, 18:18, 18:23</p> <p>repetitive [1] - 9:15</p> <p>replacement [1] - 6:10</p> <p>Reporter [1] - 20:6</p> <p>represented [1] - 8:19</p> <p>request [2] - 6:21, 8:22</p> <p>residency [1] - 5:12</p> <p>resilient [1] - 15:3</p> <p>resisting [1] - 15:4</p> <p>respect [3] - 13:24, 14:14, 16:9</p> <p>responded [1] - 12:5</p> <p>response [3] - 8:20, 10:15, 11:10</p> <p>responses [1] - 8:18</p> <p>restrict [1] - 12:10</p> <p>restriction [4] - 9:6, 9:12, 18:24, 18:25</p> <p>restrictions [8] - 8:22, 9:11, 9:17, 18:4, 18:7, 18:10, 18:15, 18:18</p> <p>result [2] - 11:10, 16:18</p> <p>return [6] - 8:21, 18:6, 18:10, 18:14, 18:23, 18:24</p> <p>review [4] - 6:18, 6:22, 12:22, 16:10</p> <p>reviewed [2] - 7:1, 10:11</p> <p>Ripa [5] - 3:6, 4:21, 13:22, 13:23, 19:5</p> <p>RIPA [4] - 1:12, 3:3, 4:13, 20:7</p> <p>Rules [1] - 4:9</p> <p>ruptured [2] - 11:6, 11:17</p> <p>S</p> <p>S1 [2] - 10:7, 10:20</p> <p>Sattler [1] - 2:8</p> <p>SATTLER [2] - 13:20, 19:2</p> <p>saw [2] - 13:7, 15:17</p> <p>scan [3] - 10:12,</p>	<p>11:3, 13:7</p> <p>scans [2] - 7:4, 15:18</p> <p>scoliosis [1] - 6:7</p> <p>Scott [1] - 5:12</p> <p>seal [1] - 20:23</p> <p>see [6] - 6:2, 8:4, 11:17, 16:17, 17:14, 17:16</p> <p>seeing [1] - 16:11</p> <p>self [1] - 10:2</p> <p>self-explanatory [1] - 10:2</p> <p>set [1] - 20:9</p> <p>settle [1] - 15:4</p> <p>seven [1] - 8:4</p> <p>several [1] - 7:4</p> <p>shifting [1] - 16:3</p> <p>shifts [1] - 15:25</p> <p>shock [1] - 15:4</p> <p>shorter [1] - 15:6</p> <p>shortly [1] - 11:1</p> <p>shoulder [1] - 12:8</p> <p>showed [3] - 10:17, 11:3, 17:24</p> <p>showing [1] - 5:1</p> <p>side [1] - 16:5</p> <p>signed [1] - 14:4</p> <p>significant [1] - 9:3</p> <p>signing [1] - 20:14</p> <p>situation [1] - 16:1</p> <p>size [1] - 17:6</p> <p>slash [5] - 10:6, 10:7, 10:20</p> <p>slightly [1] - 15:25</p> <p>small [1] - 17:5</p> <p>solemnly [1] - 4:15</p> <p>someone [2] - 8:23, 9:13</p> <p>sometimes [1] - 17:19</p> <p>somewhat [1] - 15:5</p> <p>sorry [2] - 13:23</p> <p>sort [1] - 15:14</p> <p>sorts [1] - 7:7</p> <p>South [2] - 1:15, 2:4</p> <p>space [1] - 17:8</p> <p>spaces [2] - 14:25</p> <p>specific [4] - 9:18, 9:21, 9:23, 14:9</p> <p>specifically [1] - 10:12</p> <p>specified [1] - 20:13</p> <p>spinal [3] - 5:17, 11:12, 17:18</p> <p>spine [14] - 5:14, 6:8, 8:24, 11:19, 12:7, 13:9, 14:23, 15:4, 15:10, 15:16,</p>	<p>15:21, 16:3, 16:7, 17:16</p> <p>split [1] - 5:15</p> <p>spondylolisthesi [3] - 14:19, 15:23, 15:24</p> <p>spondylosis [2] - 14:19, 15:14</p> <p>ss [1] - 20:2</p> <p>stand [1] - 9:22</p> <p>start [1] - 17:9</p> <p>state [1] - 4:19</p> <p>STATE [1] - 20:2</p> <p>State [1] - 20:5</p> <p>statement [1] - 14:3</p> <p>STATES [1] - 1:1</p> <p>stenotype [1] - 4:8</p> <p>stipulated [1] - 4:2</p> <p>stipulations [1] - 20:14</p> <p>STIPULATIONS [1] - 4:1</p> <p>stooping [1] - 12:13</p> <p>Street [2] - 1:15, 2:9</p> <p>studies [3] - 16:9, 16:22, 17:23</p> <p>subject [1] - 14:24</p> <p>subtle [1] - 16:3</p> <p>sudden [2] - 11:5, 11:17</p> <p>suffering [1] - 10:5</p> <p>suit [1] - 20:21</p> <p>Suite [3] - 1:15, 2:5, 2:9</p> <p>support [1] - 15:8</p> <p>surgeon [4] - 4:24, 4:25, 5:7, 7:22</p> <p>surgeons [1] - 7:15</p> <p>surgeries [2] - 5:23, 12:6</p> <p>surgery [4] - 6:3, 6:5, 12:9, 13:13</p> <p>sworn [2] - 4:15, 20:7</p> <p>T</p> <p>TAKEN [1] - 1:6</p> <p>tcs@sattlerbogen.com [1] - 2:10</p> <p>tear [1] - 15:16</p> <p>Telephonically [1] - 2:2</p> <p>Temple [1] - 5:13</p> <p>tend [1] - 9:4</p> <p>tendency [1] - 14:22</p> <p>tends [1] - 15:4</p>	<p>term [4] - 15:14, 15:15, 15:24, 16:6</p> <p>terms [2] - 6:17, 14:18</p> <p>testified [1] - 4:16</p> <p>testify [1] - 20:7</p> <p>TESTIMONY [1] - 20:22</p> <p>Texas [1] - 5:13</p> <p>THE [5] - 1:1, 1:2, 2:2, 2:7, 19:7</p> <p>therapy [1] - 7:5</p> <p>thicken [2] - 17:10, 17:18</p> <p>thins [1] - 17:8</p> <p>Thomas [1] - 2:8</p> <p>thrown [1] - 14:18</p> <p>TIME [1] - 1:14</p> <p>timeframe [1] - 16:14</p> <p>toll [1] - 14:23</p> <p>training [2] - 5:6, 7:21</p> <p>transcription [1] - 4:8</p> <p>traumatic [1] - 11:20</p> <p>treat [3] - 5:23, 5:24, 6:6</p> <p>treating [2] - 18:11, 18:19</p> <p>true [3] - 5:2, 18:12, 20:16</p> <p>truth [3] - 20:8, 20:9</p> <p>try [1] - 9:13</p> <p>two [1] - 10:25</p> <p>type [6] - 5:22, 5:25, 6:18, 7:13, 13:9, 18:3</p> <p>types [1] - 9:11</p> <p>typically [1] - 7:15</p> <p>U</p> <p>underneath [1] - 17:17</p> <p>understood [1] - 17:11</p> <p>unit [1] - 5:18</p> <p>UNITED [1] - 1:1</p> <p>University [1] - 5:8</p> <p>up [2] - 6:13, 16:12</p> <p>V</p> <p>valid [1] - 11:25</p> <p>variety [2] - 6:6, 7:5</p> <p>various [1] - 16:21</p> <p>vertebra [4] -</p>
---	--	--	---	---	---

15:24, 16:4, 17:2,
 17:4
vertebrae [2] -
 15:1, 15:8
view [1] - 17:24
vitae [1] - 5:3
Vitae [1] - 3:8
vs [1] - 1:6

W

waive [1] - 19:7
waived [4] - 4:5,
 4:6, 4:8, 20:15
wear [4] - 15:13,
 15:16, 16:2, 17:7
week [2] - 6:3
weekly [1] - 5:24
WHEREOF [1] -
 20:22
White [1] - 5:12
whole [1] - 20:8
William [1] - 2:3
WITNESS [2] - 3:2,
 19:7
witness [1] - 4:7
wmcmahon@
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 2:6
word [1] - 15:23
writing [1] - 20:10

Y

year [1] - 5:14

Z

zone [1] - 11:18



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October 4, 2012

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RE: David Bliss v BNSF Railway Company
(Your File No. 961205.604)

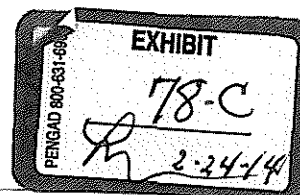
Dear Mr. Luers:

This letter is in response to the review of records regarding David Bliss. The following are opinions based on a reasonable degree of medical certainty.

1. Dr. Noble's release for Mr. Bliss to return to work without restrictions as per the request of Mr. Bliss in July 2010 was too liberal for someone with Mr. Bliss' degenerative spine condition.
2. Mr. Bliss was clearly suffering from degenerative disk disease, particularly at L3/4, L4/5, and L5/S1, prior to February 3, 2011.
3. The change in Mr. Bliss' back condition between the MRI of April 27, 2010, and the MRI of March 18, 2011, showed an increase in degenerative facet joints, foraminal narrowing and increased degenerative bone marrow at L4/5 and L5/S1.
4. The changes noted in paragraph #3, could be the result of the natural progression of a degenerative spinal condition.
5. The Functional Capacity Evaluation (FCE) of June 30, 2011, appeared to be a valid FEC so as to reflect Mr. Bliss' physical capabilities as of that date.
6. Because of multiple back surgeries and continued natural progression of his degenerative spine condition and past history of knee and shoulder joint degeneration and surgery, it would be reasonable to restrict Mr. Bliss currently to lifting no more than 20 pounds and only occasional bending, stooping and crawling.

2012 12:01 PM 003/004

Fax 4024883338



RE: David Bliss v. BNSF Railway Company

Page 2

7. From a review of Mr. Bliss' medical history, either MRI's, and degenerative condition, it was likely that Mr. Bliss' back would have continued to degenerate after 2004 regardless of his work environment.

Please contact us if further information is required.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel R. Ripa", with a long horizontal line extending to the right.

Daniel R. Ripa, M.D.

DRR/mrr

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402-488-3322

PERSONAL:

Date of Birth: August 1, 1958
Home Town: Wilber, Nebraska
Family: Wife – Geralyn
Children – Madeline & Elizabeth

EDUCATION AND MEDICAL TRAINING:

Undergraduate:

University of Nebraska – Lincoln 1976-1979

Medical School:

University of Nebraska College of Medicine 1979-1983
42nd & Dewey Avenue
Omaha, Nebraska 68105
Bachelor of Science in Medicine, May 1983
Doctor of Medicine, May 1983

Flexible Internship:

Scott & White Memorial Hospital
Temple, Texas 1983-1984

Orthopaedic Residency:

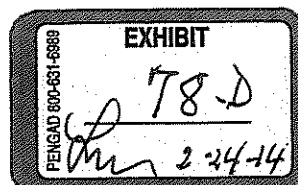
Scott & White Memorial Hospital
Temple, Texas 1984-1988

Fellowships:

Spinal Surgery Fellowship
Under the direction of Dr. S. Henry LaRocca
Elmwood Industrial Medical Center
Jefferson, Louisiana (New Orleans) July 1988 – December 1988

Fellowship in Spinal Cord Injury Treatment

Under the direction of Dr. Paul R. Meyer
Midwest Regional Spinal Cord Injury Unit
Northwestern Memorial Hospital
Chicago, Illinois January 1989 – June 1989



SPECIALIZED MEDICAL TRAINING

- Surgery of the Spine, Artificial Joint Replacement of the Knee and Hip
BIRMINGHAM HIP Resurfacing System

CERTIFICATIONS:

- Board certification in Orthopaedic Surgery – July 1991
Recertified in 2001
- Nebraska State Medical License - # 16549

HOSPITAL AFFILIATIONS:

St. Elizabeth Regional Medical Center
555 South 70th Street
Lincoln, Nebraska

BryanLGH-East
1600 South 48th Street
Lincoln, Nebraska

Lincoln Surgical Hospital
1710 South 70th Street
Lincoln, Nebraska

BryanLGH-West
2300 South 16th Street
Lincoln, Nebraska (courtesy staff)

Madonna Rehabilitation Hospital
5401 South Street
Lincoln, Nebraska 68506 (courtesy staff)

PROFESSIONAL AFFILIATIONS

- Member of Lancaster County Medical Society
- Nebraska Medical Association
- American Medical Association
- Member of the North American Spine Society
- American Academy of Orthopaedic Surgeons

PUBLICATIONS:

- "Series of 93 Cervical Spine Injuries treated by Anterior Spinal Plating", Spine, 1990 – Ripa, Meyer, Et Al.

Condensed
Transcript

Page 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

DAVID BLISS,) CASE NO. 4:12-CV-3019
)
Plaintiff,)
) DEPOSITION OF
vs.) DR. KEITH R. LODHIA
) TAKEN ON BEHALF OF
BNSF RAILWAY COMPANY,) THE DEFENDANT
)
Defendant.)

Taken at Midwest Neurosurgery & Spine Specialists,
8005 Farnam Drive, Suite 305,
Omaha, Nebraska, October 16, 2012, at 1:18 p.m.

A P P E A R A N C E S

For the Plaintiff: MR. WILLIAM J. McMAHON
HOEY & FARINA
542 South Dearborn
Suite 200
Chicago, Illinois 60605
For the Defendant: MR. JAMES B. LUERS
WOLFE SNOWDEN HURD LUERS
& AHL LLP
1248 "O" Street
Suite 800
Lincoln, Nebraska 68508

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possibly some re-draft - depending upon what -
your cross-upon you want!

Page 2	
1	I N D E X
2	Page
3	Appearances 1
4	Stipulations 3
5	Reporter's Certificate 46
6	WITNESS:
7	DR. KEITH R. LODHIA
8	Direct Examination by Mr. Luers 4
9	Cross-Examination by Mr. McMahon . . . 37
10	Redirect Examination by Mr. Luers . . . 44
11	EXHIBITS: Marked
12	56. Exam note from 6/24/10 visit 4
13	57. Note to Dr. Noble from Mr. Bliss 4
14	58. Statement of job awareness 4
15	59. Medical records 4
16	60. Physical therapy records 4
17	
18	
19	
20	
21	
22	
23	
24	
25	

Page 3	
1	S T I P U L A T I O N S
2	It is stipulated and agreed by and between the
3	parties hereto:
4	1. That the deposition of DR. KEITH R. LODHIA may
5	be taken before Lisa G. Grimminger, Registered Merit
6	Reporter, Certified Realtime Reporter, General
7	Notary Public, at the time and place set forth on
8	the title page hereof.
9	2. That the deposition is taken pursuant to
10	notice.
11	3. That the original deposition will be delivered
12	to Mr. James B. Luers, Attorney for the Defendant.
13	4. That all objections except as to form and
14	foundation shall be made at the time of the
15	deposition.
16	5. That the testimony of the witness may be
17	transcribed outside the presence of the witness.
18	6. That the signature of the witness to the
19	transcribed copy of the deposition is waived.
20	*****
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Page 4	
1	(Exhibit Nos. 56 through 60
2	were marked for
3	identification.)
4	DR. KEITH R. LODHIA,
5	Being first duly cautioned and
6	solemnly sworn as hereinafter
7	certified, was examined
8	and testified as follows:
9	(Witness's response to oath: "Yes.")
10	DIRECT EXAMINATION
11	BY MR. LUERS:
12	Q. Doctor, would you state your full
13	name and spell your last, please.
14	A. Keith R., Raman, Lodhia,
15	L-O-D-H-I-A.
16	Q. And your business address, Doctor?
17	A. It's 8005 Farnam, Suite 305, Omaha,
18	Nebraska.
19	Q. You are a physician?
20	A. Yes.
21	Q. And you have a specialty, sir?
22	A. Yes, neurosurgery.
23	Q. Any subspecialties?
24	A. Spine, spinal neurosurgeries,
25	neurosurgery of the brain, spine, peripheral nerve.
	Q. And is -- I presume you're board

Page 5	
1	certified, is that the -- board certified as a
2	neurosurgeon. Are you board certified in the
3	subspecialty as well?
4	A. We don't have board certification in
5	our spine specialty, and I'm board eligible. I
6	still have to take the oral boards which are part of
7	our secondary process. I've passed the written
8	boards sometime at the end of residency, or actually
9	at the beginning -- middle of residency, and then we
10	take them, typically, in our fifth year out. I'm
11	actually out beyond that, but I've applied over a
12	year ago. It takes a long time for them to kind of
13	get you on the list.
14	Q. I understand. How long have you
15	been practicing a neurosurgeon, Doctor?
16	A. Six years.
17	Q. And you are licensed in the State of
18	Nebraska?
19	A. Uh-huh.
20	Q. Anywhere else?
21	A. Iowa and Michigan.
22	Q. All right. Have you had your
23	deposition taken before?
24	A. Well, I think so. I know I've been
25	recorded before. I assume it was a deposition.

<p style="text-align: right;">Page 6</p> <p>1 Q. All right. Are you acquainted as 2 you sit here today -- well, strike that. 3 Are you acquainted with a patient by the 4 name of David Bliss? 5 A. Yes. 6 Q. As you sit here today, do you have 7 an independent recollection of that patient? In 8 other words, can you picture him? Do you recall 9 seeing him and talking to him? 10 A. Yes. 11 Q. All right. Do you recall who you 12 were -- who referred Mr. Bliss to you or to your 13 office? 14 A. No. 15 Q. Let's look at -- the first time you 16 saw him, at least according to my records, would 17 have been June 8th of 2011; is that right? 18 A. Probably right. I've got a note 19 there, yes. That's the earliest note I have. 20 Q. I'm sorry? 21 A. That's the earliest note that I 22 have. 23 Q. Okay. And it looks like on that 24 particular date you saw him, and you then sent a 25 letter to Dr. Kreshel, which is also dated June 8th</p>	<p style="text-align: right;">Page 8</p> <p>1 shoulder surgeries? 2 A. I don't have that printout. They 3 usually have the patient's -- the full record that 4 gets printed out here wasn't printed out. We have 5 all the little stuff that they fill in, the patients 6 fill in, themselves. They didn't print that out 7 so -- 8 Q. Like patient information? 9 A. Yeah. 10 Q. Would that -- 11 A. Would that have affected -- 12 Q. Yeah. I guess at this point you 13 weren't directed to that particular -- or any of 14 those problems; is that right? 15 A. No. 16 Q. You do reference that he had 17 previous back surgery. Do you recall or do you know 18 when those were? 19 A. Just what was stated. He had one 20 done April of that year, which was only probably a 21 couple months before I saw him, redo discectomy at 22 L3/4, and then it looked like he had some surgery 23 before L3/4. He must have mentioned then there was 24 one at L5/S1 and one at L2/3. 25 Q. Do you happen to know, Doctor, from</p>
<p style="text-align: right;">Page 7</p> <p>1 of 2011; correct? 2 A. Yes. 3 Q. All right. As of that first 4 consultation, if you recall, Doctor, do you remember 5 what sort of medical history, if any, you were 6 provided, either prior or contemporaneously with 7 that consultation? 8 A. He was a gentleman, I guess, who had 9 previous surgery at a couple of disk levels. 10 Q. The information that's contained in 11 that June 8th letter, is that the history, 12 basically, that you were provided? 13 A. Yes. 14 Q. And would that have been a history 15 that was provided by the patient as opposed to 16 separate medical records? 17 A. Looks like we just heard from the 18 patient. We did review an MRI scan, however. 19 Q. Okay. Do you remember which? 20 A. It says lumbar spine from 3-18, 21 2011, so there would have been a report there, but 22 it was before his last surgery, I guess. 23 Q. All right. As of that particular 24 first visit, Doctor, in June of 2011, were you aware 25 that the patient had had both knee surgeries and</p>	<p style="text-align: right;">Page 9</p> <p>1 reviewing the MRI whether that information was 2 accurate or not in terms of the location of those 3 surgeries and what they did? 4 A. It doesn't say from here. It wasn't 5 in the report, but it doesn't sometimes show up, 6 depending on how small the bones were taken. 7 Q. When he reported to your office in 8 June of 2011, what was the purpose of your 9 consultation? 10 A. He came -- it says he came here with 11 pain in his legs and back, and I guess he had some 12 atrophy in his legs. 13 Q. And just seeking some relief, or 14 what was the purpose of your visit? 15 A. Typically. Just says in 16 consultation. It usually says why, but it's 17 obviously for the symptoms. The next thing we talk 18 about after his surgery is that he had pain in his 19 legs and back before surgery. He was achy and 20 stiff, limited lifting because of this. 21 Q. Did he tell you -- 22 A. Correction. I think he had some 23 difficulty on the job or so because of this. 24 Q. Did he tell you anything about his 25 job or how he had gotten hurt?</p>

3 (Pages 6 - 9)

Page 10

1 A. If he did, I don't recall the
2 specifics on that. I don't remember him saying
3 anything about that. I knew he worked for the
4 railroad because he knows a friend of mine from the
5 railroad, just happenstance, because they work for
6 the same company, and he was one of his supers at
7 some point or something like that but -- so I knew
8 that he had a very physical job. I guess that's
9 about the extent of it.

10 Q. All right. Were you aware, Doctor,
11 that the he had claimed an injury in February,
12 February 3rd of 2011, on the railroad?

13 A. It's not listed on there so, no, I
14 guess I wasn't aware of that, that he had previous
15 surgery, so he must have complained to somebody
16 about that.

17 Q. Okay. I take it, Doctor, since you
18 didn't see him until at least four months after what
19 he's claiming was his injury, you're not in a
20 position to render an opinion in this case as to the
21 cause of his injury or how it happened?

22 A. No.

23 Q. All right. When you examined the
24 patient on June 8, 2011, what did you find?

25 A. At that time he had some incisions

Page 11

1 on his back, it looks like. It looked like he was
2 neurologically intact, meaning his strength and
3 sensation were good. Reflexes were notable. Eyes
4 were both equal, and he said he did have some
5 atrophy in his left thigh compared to the right
6 thigh, which I guess is what he had complained
7 about, but other than that it didn't look like it
8 was very remarkable exam.

9 Q. Okay. What did you recommend, if
10 anything?

11 A. At that time he had just had a
12 recent surgery, and because of that we ended up
13 recommending an MRI to see what had been done and
14 what was left over, whether any of that was
15 contributing to his left leg symptoms, back pain,
16 and so we recommended MRI, and then it says
17 something about a functional capacity evaluation,
18 'cause he obviously felt limited in what he could
19 do, and so we talked about possibly at some point
20 down the line getting an FCE to evaluate what his
21 limitations might be.

22 Q. And that's -- I read that under the
23 letter of June 8, 2011, as part of the plan.

24 A. Uh-huh.

25 Q. Did you order an FCE at that time

Page 12

1 or --

2 A. No, I don't think we did. I don't
3 recall. I'd have to look down there, but I don't
4 think that was ordered.

5 Q. If you'd had --

6 A. It would be in our computer orders
7 somewhere if he did.

8 Q. What kind of back surgery did he
9 have in April?

10 A. Well, it was mentioned as a redo
11 disectomy.

12 Q. And was there any -- did you have
13 any medical records or anything to verify that, or
14 was that just based on what he told you?

15 A. I suspect it was based on what he
16 told us. I mean, until we got the MRI, which it
17 looks like we got also on June 8th, so that was done
18 on June 8th too, so we did get an MRI, but that
19 wouldn't have been known that day, as we wouldn't
20 have seen those results probably until later.

21 Q. What did you see on the MRI, if
22 anything of significance?

23 A. The MRI showed changes, surgical
24 changes, it looked like, at L5/S1, L4/5, and L3/4,
25 as we talked about those levels, I think, being a

Page 13

1 component. I think he said L2/3, but he may have
2 meant L3/4. I don't know, because those levels that
3 was dictated in here are different than what are
4 showing up on the scan, those three levels.

5 Q. Okay. So he might have been off on
6 what the levels of the disectomies were?

7 A. Uh-huh.

8 Q. But, at any rate, the MRI, and that
9 was dated June 8th of 2011 also. What other
10 significant findings were on that particular report?
11 Significant to you, Doctor.

12 A. Well, basically, he had a lot of
13 marrow changes, meaning degenerative changes, at
14 really three levels. All three of those levels were
15 levels where he probably had his herniation, since
16 he had surgery in those areas. He had what they
17 call posterior retrolisthesis, meaning a
18 little bit of tipping back of the vertebrae at one
19 of the levels. That typically indicates some level
20 of instability, so basically we saw a lot of
21 degenerative changes in the lower lumbar spine.

22 Q. Now, this gentleman was -- I'm
23 sorry?

24 A. And postoperative changes.

25 Q. All right. This gentleman was

<p style="text-align: right;">Page 14</p> <p>1 55 years old when you saw him. Were the 2 degenerative changes that you saw in that particular 3 spine of Mr. Bliss significantly different than 4 other 55-year-olds? 5 A. Yeah. 6 Q. And in what regard, other than the 7 surgeries? 8 A. There was more extensive 9 degeneration of the discs. You typically don't see 10 a spondylolisthesis or instability or that kind of 11 alignment changes in a normal adult. You may see 12 some mild degenerative changes in the joints or the 13 discs with aging, but this would be what I'd 14 consider beyond that. 15 Q. Okay. Were these degenerative 16 changes the type of changes that, nevertheless, can 17 be long term, ongoing, as opposed to traumatically 18 induced? 19 A. Yes. 20 Q. Was there any way to know as you 21 looked at either the individual, himself, or the MRI 22 as to whether they were the result of trauma or just 23 simple degenerative long term? 24 A. No. I don't think there was 25 anything, at least from the MRI that we had seen</p>	<p style="text-align: right;">Page 16</p> <p>1 came in with an acute problem that needed acutely 2 fixing and I just needed to keep them out for a 3 prescribed period of time. 4 Q. All right. I gotcha. Doctor, are 5 you familiar with Dr. Noble from -- I guess he was 6 in Lincoln. 7 A. I don't know him personally, but 8 I've seen some of his patients. 9 Q. All right. Do you know if your 10 clinic or you, personally, were ever provided with 11 any records of Mr. Bliss from Dr. Noble's office 12 from 2010? 13 A. I'm not aware of that. We don't 14 have any reference that we did look at that, whether 15 they were scanned in or not. We must not have seen 16 them at the time of our visits. 17 Q. All right. I can tell you that he 18 had had a surgery in 2010, and Dr. Noble was the 19 surgeon, and I'm going to provide you what's been 20 marked as Exhibit 56 and ask you just to review that 21 briefly for me. That's a note from Dr. Noble 22 regarding the surgery and then a release to return 23 to work. Now, that's dated what, Doctor? Do you 24 see that, top of the page? 25 A. June 24th, 2010.</p>
<p style="text-align: right;">Page 15</p> <p>1 that we had ordered, that we could tell whether that 2 was acute or a chronic type of -- 3 Q. After that June 8th visit, did you 4 order or prescribe any particular restrictions for 5 the patient? In other words, did you place him on 6 any restrictions activity wise? 7 A. I don't -- once again, if I had 8 to -- if we did, we may have had a sheet we would 9 have filled out for him. It's not referenced in the 10 note -- 11 Q. You don't recall any? 12 A. -- so I don't recall that. That's 13 probably why we made the comments of the functional 14 capacity evaluation. Typically, if we're going to 15 give restrictions that aren't in the short term that 16 we don't know how long they're going to go and we 17 would tend to think it's a chronic condition, I 18 would order a functional capacity evaluation. 19 Q. And that would be typically like 20 before you impose restrictions? 21 A. Uh-huh. 22 Q. Is that a yes? 23 A. Especially if they're long term. On 24 a chronic patient I've seen once, I'm not going to 25 make restrictions on a patient like that unless they</p>	<p style="text-align: right;">Page 17</p> <p>1 Q. All right. I can show you, then, 2 Exhibit 58, which is another note from Dr. Noble, 3 ask you if you've seen this exhibit before? It's 4 dated August 5th of 2010. 5 MR. McMAHON: Fifty-eight? 6 MR. LUERS: Yeah. 7 A. I don't recall seeing that. 8 Q. (BY MR. LUERS) All right. Doctor, 9 Dr. Noble, after that surgery in 2010, released the 10 patient to full duty with the railroad for the tasks 11 that were set forth in that particular exhibit. If 12 you'd peruse that very briefly or quickly and tell 13 me, based upon your physical exam and the MRI that 14 you did in 2011 of Mr. Bliss, if at that time he 15 would have been capable of returning to that type of 16 activity. 17 A. Yeah, I would suspect so. 18 Q. You would think he would? 19 A. Uh-huh. 20 Q. And that would have been even -- 21 A. Basically, you're talking about 22 after his discectomy at the time when I would have 23 seen him? 24 Q. Correct. 25 A. Yes, he had the functional abilities</p>

5 (Pages 14 - 17)

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Page 18

1 to be able to do that. It was a matter of his
2 description of pain.
3 Q. All right. So even though there
4 was -- at least one of the tasks is may lift, carry,
5 push, and pull objects weighing between 25 and
6 50 pounds --
7 A. 50 pounds some of the time.
8 Q. 25 pounds frequently, 50 pounds
9 occasionally, those would not be unreasonable in
10 terms of --
11 A. I don't think so.
12 Q. And even though --
13 A. Based on his size, muscle strength.
14 His back MRI really didn't show anything, any gross
15 instabilities, just that little base of trace
16 retrolisthesis, which usually isn't a high
17 grade instability.
18 Q. Okay. So at least as of June of
19 2011, that would be the case too?
20 A. Yes, I believe he could have done
21 that.
22 Q. After that June of 2011 visit,
23 according to the records I have, Doctor, you saw
24 him -- well, you spoke to him on June 13, 2011. Do
25 you have that one?

Page 19

1 A. Myself or my PA? I don't have
2 June 13th.
3 Q. Well, this is the PA. I'm sorry.
4 John Calabro?
5 A. Yes. No, I don't have that. I have
6 July 13th. Did you say June or July?
7 Q. I said June.
8 A. I have a July 13th.
9 Q. Okay. I'm going to show you part of
10 Exhibit 59, and actually it's on page --
11 A. Oh, I take it back. Here it is.
12 Here's the June 13th. They were out of order. Yes,
13 got it.
14 Q. Just read that briefly, and
15 that's -- obviously, it's a note from John Calabro,
16 which is your PA?
17 A. Yes.
18 Q. And by then you had suggested the
19 FCE?
20 A. Uh-huh.
21 Q. Is that right?
22 A. Yes.
23 Q. All right. Then did you see the FCE
24 when it came in?
25 A. Yes.

Page 20

1 Q. All right. And at least as of the
2 date when that arrived, you saw that they did his
3 physical or functional testing, and they concluded
4 that he could work at the demand level of a job
5 categorized as heavy. Is that your understanding?
6 A. Yeah.
7 Q. Okay. Was there anything about that
8 FCE that you found to be invalid?
9 A. Not necessarily. They just said he
10 developed some pain.
11 Q. Right, but I'm talking about just
12 the testing results, itself, at this point. Is
13 there anything in there that jumped out at you?
14 A. Well, they didn't say anything about
15 it being invalid or that he didn't pass any of the
16 tests, so no. I would say no.
17 Q. Okay. So then you saw him on
18 June 13th; is that right? Or, excuse me, July 13th.
19 A. Yes.
20 Q. And would you have actually seen him
21 on that day, or would Mr. Calabro have?
22 A. We probably both saw him, I'm
23 guessing.
24 Q. And that's when he came back
25 complaining of additional pain after the FCE; is

Page 21

1 that right?
2 A. Yes, or I don't know if it's because
3 of the FCE but --
4 Q. No. I understand.
5 A. Yeah. Increasing pain, yes.
6 Q. What did you attribute that
7 increased pain to, any particular thing?
8 A. No. Just the exacerbation of
9 degenerative changes. You know, anything can flare
10 that up, sometimes minor things. I wasn't sure what
11 would cause that.
12 Q. All right. And you ordered another
13 MRI at that time?
14 A. Right, and an EMG.
15 Q. And an EMG?
16 A. He had pain in a new distribution, I
17 guess, is what he was complaining of.
18 Q. Okay. Tell me what you found with
19 either of those test results.
20 A. Let's see. I don't know if I have
21 those actual tests. I have a phone note based on
22 our tests. I don't print up --
23 Q. I think that's the EMG.
24 A. That's the MRI. I've got that, so
25 that didn't show anything essentially different than

<p style="text-align: right;">Page 22</p> <p>1 the previous one. There's the EMG. Okay. And the</p> <p>2 EMG showed a chronic right L5 radiculopathy. That's</p> <p>3 what John was talking about in the July 15th note.</p> <p>4 Q. So let me back up just a moment. So</p> <p>5 the repeat MRI that would have been done on July 13,</p> <p>6 2011, basically, you didn't see anything</p> <p>7 significantly different from the MRI that you'd</p> <p>8 looked at when you first saw him in June?</p> <p>9 A. Right.</p> <p>10 Q. Correct?</p> <p>11 A. Right, correct.</p> <p>12 Q. So you couldn't attribute -- at</p> <p>13 least from the results of the MRI, you couldn't</p> <p>14 attribute the reason for the additional pain?</p> <p>15 A. The additional pain, right, correct.</p> <p>16 Q. Then, the EMG, what is the purpose</p> <p>17 of that?</p> <p>18 A. The EMG is to look for acute nerve</p> <p>19 compression versus old nerve compression versus</p> <p>20 location, be it peripheral nerve or maybe pinched at</p> <p>21 the lumbar spine, so it's a way to help us quantify</p> <p>22 whether something's acute, chronic, and maybe what</p> <p>23 location, which nerve, et cetera.</p> <p>24 Q. And what did you find again?</p> <p>25 A. The EMG showed that right L5 chronic</p>	<p style="text-align: right;">Page 24</p> <p>1 and the nerve may or may not heal.</p> <p>2 Q. So that may have been a condition</p> <p>3 that was there from as early as 2003, when he was</p> <p>4 having these first back symptoms?</p> <p>5 A. Possibly.</p> <p>6 Q. Okay. No way to really know on</p> <p>7 that?</p> <p>8 A. No, and we don't even know if the</p> <p>9 chronic EMG finding correlates even with his</p> <p>10 increased pain at the time.</p> <p>11 Q. Okay.</p> <p>12 A. May very well not.</p> <p>13 Q. And how significant was the EMG</p> <p>14 finding? In other words --</p> <p>15 A. It was mild.</p> <p>16 Q. -- you said mild? Okay.</p> <p>17 A. Which may or may not even cause</p> <p>18 symptoms in some people so --</p> <p>19 Q. And then you or your physician's</p> <p>20 assistant spoke with David Bliss's wife on July 15;</p> <p>21 correct?</p> <p>22 A. Yes.</p> <p>23 Q. All right.</p> <p>24 A. Got that.</p> <p>25 Q. And then who sent the patient to</p>
<p style="text-align: right;">Page 23</p> <p>1 radiculopathy, meaning it's -- that would be</p> <p>2 consistent with an old injury.</p> <p>3 Q. Okay. "Old" meaning --</p> <p>4 A. Not acute, something that's not</p> <p>5 healing further. It's nothing new that's ongoing or</p> <p>6 a new injury. There's no re-innervation occurring,</p> <p>7 meaning the nerve is not trying to heal or in the</p> <p>8 process of denervating. It's just stably or</p> <p>9 chronically impaired.</p> <p>10 Q. Is there a -- what type of</p> <p>11 condition, injury or degeneration can result in</p> <p>12 those kinds of findings on the EMG?</p> <p>13 A. You can have nerve damage from, say,</p> <p>14 a herniated disk or some other form of pinching of</p> <p>15 the nerve.</p> <p>16 Q. Can that be degenerative in nature</p> <p>17 also, or does it have to be an acute injury?</p> <p>18 A. Typically, it was a result of</p> <p>19 something that had injured it, so at some point it</p> <p>20 probably was an acute injury, but it could be</p> <p>21 anything from a stretch to a compressive phenomenon,</p> <p>22 meaning, you know, nerve stretch or actual physical</p> <p>23 compression on the nerve. Maybe it was a herniated</p> <p>24 disk, maybe it was a bone spur that he'd had</p> <p>25 previously from other operations that was taken off,</p>	<p style="text-align: right;">Page 25</p> <p>1 Madonna, was that you, for some rehab?</p> <p>2 A. I don't know if he went to Madonna.</p> <p>3 We may have. I don't know if he did physical</p> <p>4 therapy or not.</p> <p>5 Q. Let me show you a report that I got,</p> <p>6 Doctor. I think that's from Madonna.</p> <p>7 A. It looks like we did.</p> <p>8 Q. And that's dated what?</p> <p>9 A. 7-26, 2011.</p> <p>10 Q. Okay. So assuming that you guys</p> <p>11 sent him for rehab, do you recall what you were</p> <p>12 hoping to gain at that point in time through that</p> <p>13 rehab? If you want to look at this record,</p> <p>14 that's --</p> <p>15 A. What date was that again?</p> <p>16 Q. That was July 26th, is the date of</p> <p>17 service.</p> <p>18 A. Okay. Was that before or after his</p> <p>19 functional capacity evaluation?</p> <p>20 Q. Actually, it was after.</p> <p>21 A. That was after his FCE?</p> <p>22 Q. Yeah. The FCE was dated June 30th.</p> <p>23 A. Okay. My guess is we were just</p> <p>24 trying something nonoperative as opposed to a three</p> <p>25 level fusion or something.</p>

Page 26

1 Q. Do you know offhand, Doctor, or do
2 your records reflect any follow-up to that rehab?
3 In other words, I can't recall at the conclusion of
4 that report whether they recommended anything
5 further or --
6 A. He believed he was at maximum
7 medical improvement and deferred to either of us.
8 He said, Use the information in the FCE as well as
9 the physical exam to recommend future work
10 restrictions, and he didn't recommend any work
11 restrictions today with him, so he kind of basically
12 said whatever we said.
13 Q. Then keep going in that. And you're
14 looking at exhibit -- what's the number on the front
15 of that exhibit, Doctor?
16 A. Exhibit 59.
17 Q. All right. And keep going, and I
18 think there's -- the next, is it August 25th, 2011,
19 either report or --
20 A. Uh-huh.
21 Q. What is that? Is that from Madonna
22 again?
23 A. Yes.
24 Q. And at that point in time, were they
25 recommending any further plan for Mr. Bliss?

Page 27

1 A. No follow-up, just continue physical
2 therapy is something he recommended. No narcotics,
3 took the anti-inflammatories, nonnarcotic medicines.
4 Q. At some point in time, I thought I
5 read in one of those Madonna reports work hardening
6 or condition program. Do you know whether or not
7 there was any follow-up in that regard or whether he
8 engaged in any, Mr. Bliss?
9 A. I'm not aware of that.
10 Q. Let me take a quick look at it,
11 Doctor. I'm sorry. I'm looking at page -- it's
12 MRH5 of Exhibit 59 in the second-to-the-last
13 paragraph. Do you know it references work hardening
14 and some conditioning program?
15 A. Yes, yes. It says something about
16 continuing to advance to more functional
17 conditioning and work hardening, especially if
18 there's no surgery planned.
19 Q. All right. And at that point in
20 time, there was no surgery planned, I take it?
21 A. No.
22 Q. Do you know if there was any
23 follow-up in that regard by either the rehab people
24 or Mr. Bliss?
25 A. Not that I'm aware of.

Page 28

1 Q. Okay. Put that exhibit back
2 together. Then your next -- the next time you
3 actually saw Mr. Bliss would have been when?
4 A. September 2nd.
5 Q. Okay. What was the purpose of that
6 visit?
7 A. We saw him in consultation, reviewed
8 his notes, I suppose, and re-review his complaints
9 that he was having -- he was talking about when he
10 got there.
11 Q. Now, at that point in time, your
12 physical exam noted that basically it was unchanged
13 except with some depressed reflexes and now some S1
14 radicular symptoms; correct?
15 A. Uh-huh.
16 Q. And that's yes?
17 A. Yes.
18 Q. Other than that, as far as his
19 physical exam, was that pretty much the same as it
20 was when you first saw him in June of 2011? And I
21 realize his subjective complaints were different
22 but --
23 A. Yes.
24 Q. Okay. You say down there on -- down
25 at the last paragraph of that first page of that

Page 29

1 September 2nd, 2011 report, it says he can't
2 function at his job with his current pain level and
3 would need to be in a light-duty situation. I take
4 it, Doctor, and you correct me if I'm wrong, but
5 basically what you're saying is if you could
6 eliminate his pain or reduce it, then that -- then
7 he could function at more than a light level; is
8 that what you were saying?
9 A. Pain is what limited his
10 functioning.
11 Q. All right. And the pain, obviously
12 those -- not to diminish it, but those are
13 subjective complaints. You can't measure that;
14 correct?
15 A. Correct.
16 Q. Otherwise, his physical exam was
17 virtually the same?
18 A. Correct.
19 Q. What did you recommend, if anything,
20 at that point in time?
21 A. Still wasn't sure what was causing
22 his pain based on our physical exam and our imaging
23 and our EMG; so, therefore, we wanted to see if
24 maybe his pain source was in the joints, the facet
25 joints, themselves, in those three levels that had

<p style="text-align: right;">Page 30</p> <p>1 that degeneration, and so we recommended maybe facet 2 blocks or possibly facet rhizolysis. If facet 3 blocks helped, they were a longer term solution. 4 Q. And the rhizotomy, is that different 5 than the facet blocks? 6 A. No. 7 Q. Same thing? 8 A. Well, they actually are different. 9 Usually, one's referred to as using medications. 10 The rhizolysis is typically something they use a 11 radiofrequency generator to actually create a lesion 12 not chemically, but electrically. 13 Q. Okay. And you recommended that, and 14 I take it, then, he followed through on that, as far 15 as you know; correct? 16 A. Yes. 17 Q. Your next visit was when, Doctor? 18 A. Well, I guess we spoke to him on the 19 phone, but we didn't see him until November 2011. 20 Q. That would be November 7th? 21 A. Yes. 22 Q. What did you do on that particular 23 visit? 24 A. We discussed his MRI findings with 25 him, we discussed what he had done since I'd seen</p>	<p style="text-align: right;">Page 32</p> <p>1 suggesting had improved significantly, but his 2 nerve-like symptoms that he had were still bothering 3 him, and, as he said, were limiting him. 4 Q. And I think in that report, Doctor, 5 you indicate that at that point in time you didn't 6 think fusion would do any good for him? 7 A. Correct. 8 Q. You were not? 9 A. He didn't seem to have mechanical 10 low back pain that he had had before, and I told him 11 that a fusion is mainly for mechanical low back pain 12 unless you have some nerves to decompress, which we 13 did not based on our MRI or EMG studies. 14 Q. Do you know at that point in time 15 what kind of pain prescription he was on, or had you 16 prescribed pain medication? Was that -- was he 17 getting that from somewhere else? 18 A. I suspect he would have gotten that 19 from somebody else. Typically, we don't prescribe 20 pain medications unless we've done surgery. We let 21 their other doctors take care of that. 22 Q. Do you know if you ever have seen 23 him since November of 2011? 24 A. I don't believe I have. 25 Q. Okay.</p>
<p style="text-align: right;">Page 31</p> <p>1 him, which at that time he had rhizolysis after 2 having had his injections, still complained of some 3 burning symptoms in the back of his heels and feet 4 with walking. 5 Q. According to that November 7th 6 letter you have, he actually had an excellent 7 response to the rhizolysis with near complete 8 resolution of his lumbar back pain; is that correct? 9 A. Right. 10 Q. And he had the heels and lateral 11 foot pain if he walked for 20 minutes or more; 12 correct? 13 A. He was complaining more from what 14 I'd say is nerve-like symptoms as opposed to just 15 the mechanical back symptoms. 16 Q. But those symptoms were located now 17 in the feet; correct? 18 A. And the legs. He complained of some 19 aching in the hips too, but, yes, it looks like they 20 were in the feet and legs. 21 Q. At least from a physical standpoint, 22 at that point in time -- or from a functional 23 standpoint, it would have been improved, then, could 24 you conclude, because of the lack of lumbar pain? 25 A. Yes. I think his back pain he was</p>	<p style="text-align: right;">Page 33</p> <p>1 A. Not from my notes. 2 Q. So as you sit here today, you don't 3 know what his condition is; correct? 4 A. Correct. 5 Q. I take it, then, you would agree 6 with me, Doctor, that at least from the first time 7 you saw him until the last time you saw him, if 8 anything, his condition improved? 9 A. Correct. 10 Q. And you would agree with me that at 11 least from a cursory examination of Exhibit 58, you 12 still think he would be able to perform those types 13 of tasks with his physical condition? 14 A. I'm not sure. 15 Q. Okay. Which one would cause you 16 some hesitancy? 17 A. Well, to do a half a day of sitting 18 or standing when he said he couldn't stand or 19 couldn't walk for more than 20 minutes or so. 20 Q. Okay. But you don't -- do you know 21 the reason that he couldn't walk for 20 minutes? 22 A. No. I had no objective evidence of 23 why he couldn't do that. 24 Q. Okay. Doctor, do you agree that 25 Mr. Bliss was clearly suffering from degenerative</p>

Page 34

1 disk disease at that L3/4 through L5/S1 as of the
 2 time you saw him first in June of 2011?
 3 A. Yes.
 4 Q. And any changes you noted in MRIs
 5 from the -- well, strike that.
 6 Did you ever see any MRI results from
 7 anything before June of 2011?
 8 A. Yes.
 9 Q. Was there -- can you tell me what,
 10 if any, significant changes there were between those
 11 two MRIs and which -- let me back up. Which MRI did
 12 you see that was before 2000 and --
 13 A. March 18th, 2011.
 14 Q. Okay. And then, at least from
 15 March 18, 2011, through the last MRI you took, there
 16 wasn't any real significant changes; is that right?
 17 A. Well, the March -- there was a
 18 change from the March 18th one from the MRIs that I
 19 saw, because he had surgery between these two.
 20 Q. Okay. Which two are we talking
 21 about? I'm sorry. I'm confused.
 22 A. You asked if I saw an MRI before
 23 June, and the answer is yes. We saw the March 18th
 24 one, which was done before his April surgery, and he
 25 had a recurrent disk herniation at L3/4 on that

Page 35

1 study.
 2 Q. Okay. I gotcha.
 3 A. In June that wasn't mentioned there
 4 anymore so --
 5 Q. Gotcha. That was repaired by the
 6 time the June MRI was taken care of?
 7 A. Right, yes.
 8 Q. Other than that change was there any
 9 significant change?
 10 A. No.
 11 Q. And did you see any MRIs taken prior
 12 to March of 2011?
 13 A. No.
 14 Q. Okay. Doctor, are you aware that
 15 you were identified as an expert witness because you
 16 were one of the treating physicians in this
 17 particular case that Mr. Bliss has against the
 18 railroad?
 19 A. Yes.
 20 Q. Okay. You're aware of that now, at
 21 any rate; right?
 22 A. Yeah.
 23 Q. You've not recommended any
 24 restrictions, either temporary or permanent, for
 25 Mr. Bliss; correct?

Page 36

1 A. Correct.
 2 Q. And you've not rendered any opinions
 3 or been asked to render any opinions as to any
 4 temporary or permanent restrictions for Mr. Bliss;
 5 correct?
 6 A. Correct.
 7 Q. And other than your physical exam
 8 and the MRI and EMG testing that you've done for
 9 Mr. Bliss, you don't know what his current condition
 10 is or his functional limitations or his medication
 11 requirements are?
 12 A. No.
 13 Q. And you have not been asked, nor
 14 have you rendered any opinion or have any opinion as
 15 to whether or not Mr. Bliss should return to any
 16 particular job or not return to any job; correct?
 17 A. Correct.
 18 Q. And as far as his conditions,
 19 whatever they are right now, you don't know whether
 20 they're temporary or permanent?
 21 A. Correct.
 22 Q. And, again, I think I already asked
 23 you this, but whatever his conditions are, you have
 24 no opinions, nor have you been asked as to what the
 25 cause of those conditions are?

Page 37

1 A. No.
 2 Q. Doctor, I have no further questions.
 3 CROSS-EXAMINATION
 4 BY MR. McMAHON:
 5 Q. Doctor, just briefly, going back to
 6 the September 2nd, 2011, note, at the bottom there
 7 in Recommendations --
 8 A. Uh-huh.
 9 Q. -- it seems that you and David had a
 10 long discussion about the conditions, and at that
 11 time you stated that he certainly can't function at
 12 his job with the current pain level and he would
 13 need to be in a light-duty situation?
 14 A. Yes, and that was related to his
 15 pain.
 16 Q. Okay. And so, depending on his pain
 17 level, he may or may not still be at that light-duty
 18 situation that you thought he was that was
 19 appropriate in September 2nd, 2011?
 20 A. Correct. I told him -- basically,
 21 he was telling me that the work was bothering him or
 22 repetitive type of twisting and movement and he
 23 couldn't function in his job. When he talked to me,
 24 he basically said he couldn't do these certain
 25 things and it was causing -- it was because of pain,

Page 38

37:5
--39:9
BNSF
objects to
the
testimony
as hearsay
without an
exception
and as not
relevant.
Fed. R.
Evid. 402,
403, 801
and 802.
Ruling:
Overruled

1 and I said, "Well, if you can't do those things, you
2 can't do those things," and so that was in reference
3 to that, that maybe light duty might be more helpful
4 because of his pain doing his current -- you know,
5 his current job description, but I was not -- I did
6 not prescribe him any light duty.

7 Q. Okay. And you weren't asked by the
8 railroad?

9 A. I don't believe so.

10 Q. All right.

11 A. I don't have any forms that I recall
12 filling out.

13 Q. All right. And then, in the
14 November 7, 2011, note, you stated at the bottom
15 that he would likely needed to continue on
16 medications, at least in some form, as needed
17 indefinitely unless he gets some relief with the
18 spinal cord stimulator?

19 A. Uh-huh.

20 Q. What was this recommendation about?

21 A. Basically, he had been placed on
22 anti-inflammatories and other medicines for his pain
23 which was used to manage that, and I felt that his
24 pain was probably chronic and he was likely going to
25 need to be on medications if this didn't work for

Page 39

1 his nerves, and we wouldn't know how long or what
2 medicines those might be, but there may be nothing
3 else, in other words, for him.

4 Q. And did you make the referral to
5 Dr. Donovan at that time, do you know?

6 A. For the spinal cord stimulator?

7 Q. Right, for the consult.

8 A. Yes, we probably would have at that
9 time. I don't know if he went or not.

10 Q. But from the November 7, 2011, note,
11 it seems that you were making the referral to more
12 of a pain management treatment plan; is that fair to
13 say?

14 A. Yes. He was having nerve pain at
15 that time, so sending him to a pain manager or
16 somebody that could maybe identify whether he would
17 even be a candidate for something like that spinal
18 cord stimulator for some chronic nerve type of
19 damage or pain, and that was my thought, is that
20 that might be an option for him.

21 Q. And the procedure, I guess it was
22 done by Dr. Devney, is that correct --

23 A. Uh-huh.

24 Q. -- in October of 2011, the
25 rhizolysis?

Page 40

1 A. Rhizolysis, yeah.

2 Q. Rhizolysis? Did that work in
3 correcting some of the symptoms that Mr. Bliss had?

4 A. Yes. That's what he reported, that
5 it helped him with his low back pain significantly.

6 Q. All right. And how? What's the --
7 how does that work? How does the rhizolysis
8 function to alleviate the low back pain?

9 A. Basically, it's -- I would say it's
10 a newer procedure, the idea being if you take away
11 the painful innervation of the joints in the back,
12 the facet joints, by basically destroying or
13 disrupting one of the nerves through heat or some
14 other type of injury that you can numb that joint
15 innervation; therefore, if you have pain in that
16 joint, you won't feel the pain in the back, and so
17 it's a pain-relieving procedure by basically
18 destroying part of the sensory portions of the
19 nerves to those joints.

20 Q. And is it a permanent fix for
21 patients like Mr. Bliss?

22 A. Most of the pain doctors consider it
23 a semi permanent or longer term but not permanent,
24 necessarily. Although some people supposedly get
25 permanent relief, most of the doctors, I think,

Page 41

1 suggest that it may be a year to two years, tops.

2 Q. And that's because the nerves
3 regenerate themselves?

4 A. Yes, the sensory branches can
5 regenerate.

6 Q. And if the sensory branches
7 regenerate in that area where the rhizolysis was
8 performed, is that the risk, is that the symptoms
9 then will come back, the mechanical back pain
10 symptoms will return?

11 A. Yes.

12 Q. Is that correct?

13 A. Yes.

14 Q. Okay. And then, in those patients
15 where the nerve is regenerated and the symptoms of
16 mechanical back pain have returned, if those
17 patients return to see you, is there -- can you do
18 another rhizolysis? What's the course of treatment
19 at that time?

20 A. That, I typically would leave up to
21 the pain doctors, but I have heard of patients going
22 back and getting another rhizolysis if they have
23 good relief, but it does reoccur. I don't know what
24 the success rate of that is for a repeat procedure
25 like that.

Page 42

1 Q. All right. Now, there's been some
2 mention in your records about a fusion, and in
3 Mr. Bliss' case was it that he was a candidate for a
4 three-level fusion?
5 A. That's what I offered him. If we
6 were going to do a fusion, we were going to have to
7 address all three of those degenerative levels, any
8 one of or all of those three contributing to his
9 pain, potentially.
10 Q. And fusion surgery, just by its own
11 nature, is a permanent -- you're addressing a
12 permanent type of fix for someone with mechanical
13 back pain; correct?
14 A. Correct.
15 Q. And people that undergo the
16 rhizolysis procedure, are they also candidates for
17 fusion surgeries if the mechanical back pain
18 symptoms return after the nerves regenerate?
19 A. Sometimes.
20 Q. All right. And is there anything
21 about the rhizolysis procedure that excludes
22 patients from future fusion surgery?
23 A. Not necessarily.
24 Q. Okay.
25 A. I'd say not from the procedure,

Page 43

1 itself.
2 Q. That's what I meant. Is there
3 something that would then sort of --
4 A. If the procedure were done and it
5 gave no relief at a level that they did it, then I
6 would suspect that I wouldn't fuse a level that
7 didn't work from the other procedure either if I was
8 using that as a diagnostic procedure, but typically
9 those would be done with a block and not a
10 rhizolysis.
11 Q. Okay, all right. 'Cause then fusion
12 obviously wouldn't help those symptoms if the
13 rhizolysis, or the block, didn't help those
14 symptoms; correct?
15 A. Typically.
16 Q. So the thinking goes; right?
17 A. Yes, and in his case I think the
18 joints were a big component of his pain. The other
19 issue is the disk and the nerve, which isn't
20 addressed by rhizolysis because that's -- we're
21 talking about a little more anterior and different
22 portions of the nerve, not the nerve innervation to
23 the joint, so it gets a little complex using them to
24 totally decide whether you're going to do that
25 surgery or not.

Page 44

1 Q. I understand. Thank you, Doctor.
2 REDIRECT EXAMINATION
3 BY MR. LUERS:
4 Q. But just so we're clear, Doctor, you
5 didn't recommend and even told him in the November
6 letter that the fusion would not make him any
7 better, and you didn't recommend that procedure?
8 A. Based on his constellation of
9 symptoms that he had at that time, which were almost
10 all nerve related, which I couldn't pinpoint, I had
11 no target. Before our target was back pain and
12 generation back pain. The symptoms sounded like
13 they got significantly better, and I couldn't
14 improve upon that with fusion, at least when I saw
15 him, and that's why I told him that.
16 Q. I gotcha. And you've not seen
17 anything that changed your opinion in that regard?
18 A. No.
19 Q. And you're not aware of any medical
20 doctor at this point advising him to get a fusion?
21 A. No.
22 Q. Doctor, I don't think I asked you,
23 and I just very quickly will ask you if you ever saw
24 this letter that Mr. Bliss wrote to Dr. Noble, and
25 that is Exhibit 57. I'm doubting you've ever seen

Page 45

1 it.
2 A. No.
3 Q. You've never seen it?
4 A. No.
5 Q. I take it that the language in here
6 where he says, when I go to work as a carman even
7 after January of 2011, it's not a heavy load, was
8 that different than what he told you about his
9 carman duties?
10 A. I was under the impression that he
11 had some heavy physical labor involved in it. I
12 don't know the specifics, but that was a physical
13 job.
14 Q. Did you ever -- did he ever talk
15 specifics with you in terms of how heavy or how
16 physical?
17 A. I don't recall that conversation.
18 MR. LUERS: I have nothing further.
19 MR. McMAHON: I have nothing further.
20 MR. LUERS: Doctor, you have a right to
21 read and review the transcribed deposition, or you
22 can waive that right.
23 THE WITNESS: That's fine. Waive it.
24 (Deposition concluded at 2:07 p.m.)
25

C E R T I F I C A T E

I, Lisa G. Grimminger, RMR, CRR, General
Notary Public, duly commissioned, qualified, and
acting under a general notarial commission within
and for the State of Nebraska, do hereby certify
that:

DR. KEITH R. LODHIA

was by me first duly sworn to tell the truth, the
whole truth, and nothing but the truth; that the
foregoing deposition was taken by me at the time and
place herein specified and in accordance with the
within stipulations; that I am not counsel,
attorney, or relative of either party or otherwise
interested in the event of this suit.

IN TESTIMONY WHEREOF, I have hereunto set my
hand officially and attached my notarial seal at
Lincoln, Nebraska, this 24th day of October, 2012.

General Notary Public

[& - bliss]

Page 1

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13th 19:2,6,8,12	4 2:8,12,13,14,15,16	actual 21:21 23:22	35:20 44:19
20:18,18	3:13	acute 15:2 16:1	awareness 2:14
15 24:20	44 2:10	22:18,22 23:4,17,20	
15th 22:3	46 2:5	acutely 16:1	b
16 1:10	4:12 1:2	additional 20:25	b 1:16 3:12
18 34:15	5	22:14,15	back 8:17 9:11,19
18th 34:13,18,23	5 3:16	address 4:15 42:7	11:1,15 12:8 13:18
1:18 1:10	50 18:6,7,8	addressed 43:20	18:14 19:11 20:24
2	542 1:14	addressing 42:11	22:4 24:4 28:1 31:3
2 3:9	55 14:1,4	adult 14:11	31:8,15,25 32:10,11
20 31:11 33:19,21	56 2:12 4:1 16:20	advance 27:16	34:11 37:5 40:5,8
200 1:14	57 2:13 44:25	advising 44:20	40:11,16 41:9,9,16
2000 34:12	58 2:14 17:2 33:11	aging 14:13	41:22 42:13,17
2003 24:3	59 2:15 19:10 26:16	ago 5:12	44:11,12
2010 16:12,18,25	27:12	agree 33:5,10,24	base 18:15
17:4,9	5th 17:4	agreed 3:2	based 12:14,15
2011 6:17 7:1,21,24	6	ahl 1:17	17:13 18:13 21:21
9:8 10:12,24 11:23	6 3:18	alignment 14:11	29:22 32:13 44:8
13:9 17:14 18:19,22	6/24/10 2:12	alleviate 40:8	basically 7:12 13:12
18:24 22:6 25:9	60 2:16 4:1	answer 34:23	13:20 17:21 22:6
26:18 28:20 29:1	60605 1:15	anterior 43:21	26:11 28:12 29:5
30:19 32:23 34:2,7	68508 1:18	anti 27:3 38:22	37:20,24 38:21 40:9
34:13,15 35:12 37:6	7	anymore 35:4	40:12,17
37:19 38:14 39:10	7 38:14 39:10	appearances 2:3	beginning 5:9
39:24 45:7	7-26 25:9	applied 5:11	behalf 1:5
2012 1:10 46:17	7th 30:20 31:5	appropriate 37:19	believe 18:20 32:24
24th 16:25 46:17	8	april 8:20 12:9	38:9
25 18:5,8	8 10:24 11:23	34:24	believed 26:6
25th 26:18	800 1:18	area 41:7	better 44:7,13
26th 25:16	8005 1:9 4:16	areas 13:16	beyond 5:11 14:14
2:07 45:24	8th 6:17,25 7:11	arrived 20:2	big 43:18
2nd 28:4 29:1 37:6	12:17,18 13:9 15:3	asked 34:22 36:3,13	bit 13:18
	a	36:22,24 38:7 44:22	bliss 1:2 2:13 6:4,12
3	abilities 17:25	assistant 24:20	14:3 16:11 17:14
3-18 7:20	able 18:1 33:12	assume 5:25	26:25 27:8,24 28:3
		assuming 25:10	33:25 35:17,25 36:4
		atrophy 9:12 11:5	36:9,15 40:3,21
		attached 46:16	42:3 44:24

bliss's 24:20 block 43:9,13 blocks 30:2,3,5 bnsf 1:5 board 4:25 5:1,2,4,5 boards 5:6,8 bone 23:24 bones 9:6 bothering 32:2 37:21 bottom 37:6 38:14 brain 4:24 branches 41:4,6 briefly 16:21 17:12 19:14 37:5 burning 31:3 business 4:15	certified 3:6 4:6 5:1 5:1,2 certify 46:5 cetera 22:23 change 34:18 35:8,9 changed 44:17 changes 12:23,24 13:13,13,21,24 14:2 14:11,12,16,16 21:9 34:4,10,16 chemically 30:12 chicago 1:15 chronic 15:2,17,24 22:2,22,25 24:9 38:24 39:18 chronically 23:9 claimed 10:11 claiming 10:19 clear 44:4 clearly 33:25 clinic 16:10 come 41:9 comments 15:13 commission 46:4 commissioned 46:3 company 1:5 10:6 compared 11:5 complained 10:15 11:6 31:2,18 complaining 20:25 21:17 31:13 complaints 28:8,21 29:13 complete 31:7 complex 43:23 component 13:1 43:18 compression 22:19 22:19 23:23 compressive 23:21 computer 12:6 conclude 31:24 concluded 20:3 45:24	conclusion 26:3 condition 15:17 23:11 24:2 27:6 33:3,8,13 36:9 conditioning 27:14 27:17 conditions 36:18,23 36:25 37:10 confused 34:21 consider 14:14 40:22 consistent 23:2 constellation 44:8 consult 39:7 consultation 7:4,7 9:9,16 28:7 contained 7:10 contemporaneously 7:6 continue 27:1 38:15 continuing 27:16 contributing 11:15 42:8 conversation 45:17 copy 3:19 cord 38:18 39:6,18 correct 7:1 17:24 22:10,11,15 24:21 28:14 29:4,14,15,18 30:15 31:8,12,17 32:7 33:3,4,9 35:25 36:1,5,6,16,17,21 37:20 39:22 41:12 42:13,14 43:14 correcting 40:3 correction 9:22 correlates 24:9 counsel 46:12 couple 7:9 8:21 course 41:18 court 1:1 create 30:11 cross 2:9 37:3 crr 46:2	cs1540360 1:25 current 29:2 36:9 37:12 38:4,5 cursory 33:11 cv 1:2
c			d
c 1:12 46:1,1 calabro 19:4,15 20:21 call 13:17 candidate 39:17 42:3 candidates 42:16 capable 17:15 capacity 11:17 15:14,18 25:19 care 32:21 35:6 carman 45:6,9 carry 18:4 case 1:2 10:20 18:19 35:17 42:3 43:17 categorized 20:5 cause 10:21 11:18 21:11 24:17 33:15 36:25 43:11 causing 29:21 37:25 cautioned 4:5 certain 37:24 certainly 37:11 certificate 2:5 certification 5:4			d 2:1 4:14 damage 23:13 39:19 date 6:24 20:2 25:15 25:16 dated 6:25 13:9 16:23 17:4 25:8,22 david 1:2 6:4 24:20 37:9 day 12:19 20:21 33:17 46:17 dearborn 1:14 decide 43:24 decompress 32:12 defendant 1:5,6,16 3:12 deferred 26:7 degeneration 14:9 23:11 30:1 degenerative 13:13 13:21 14:2,12,15,23 21:9 23:16 33:25 42:7 delivered 3:11 demand 20:4 denervating 23:8 depending 9:6 37:16 deposition 1:4 3:4,9 3:11,15,19 5:23,25 45:21,24 46:10 depressed 28:13 description 18:2 38:5 destroying 40:12,18 developed 20:10 devney 39:22 diagnostic 43:8 dictated 13:3

[different - gotcha]

Page 3

different 13:3 14:3 21:25 22:7 28:21 30:4,8 43:21 45:8	earliest 6:19,21	eyes 11:3	forth 3:7 17:11
difficulty 9:23	early 24:3	f	found 20:8 21:18
diminish 29:12	eight 17:5	f 46:1	foundation 3:14
direct 2:8 4:9	either 7:6 14:21 21:19 26:7,19 27:23 35:24 43:7 46:13	facet 29:24 30:1,2,2 30:5 40:12	four 10:18
directed 8:13	electrically 30:12	fair 39:12	frequently 18:8
discs 14:9,13	eligible 5:5	familiar 16:5	friend 10:4
discussed 30:24,25	eliminate 29:6	far 28:18 30:14 36:18	front 26:14
discussion 37:10	emg 21:14,15,23 22:1,2,16,18,25 23:12 24:9,13 29:23 32:13 36:8	farina 1:13	full 4:11 8:3 17:10
disease 34:1	ended 11:12	farnam 1:9 4:16	function 29:2,7 37:11,23 40:8
disk 7:9 23:14,24 34:1,25 43:19	engaged 27:8	fce 11:20,25 19:19 19:23 20:8,25 21:3 25:21,22 26:8	functional 11:17 15:13,18 17:25 20:3 25:19 27:16 31:22 36:10
diskectomies 13:6	equal 11:4	february 10:11,12	functioning 29:10
diskectomy 8:21 12:11 17:22	especially 15:23 27:17	feel 40:16	further 23:5 26:5,25 37:2 45:18,19
disrupting 40:13	essentially 21:25	feet 31:3,17,20	fuse 43:6
distribution 21:16	et 22:23	felt 11:18 38:23	fusion 25:25 32:6,11 42:2,4,6,10,17,22 43:11 44:6,14,20
district 1:1,1	evaluate 11:20	fifth 5:10	future 26:9 42:22
doctor 4:11,15 5:15 7:4,24 8:25 10:10 10:17 13:11 16:4,23 17:8 18:23 25:6 26:1,15 27:11 29:4 30:17 32:4 33:6,24 35:14 37:2,5 44:1,4 44:20,22 45:20	evaluation 11:17 15:14,18 25:19	filled 15:9	g
doctors 32:21 40:22 40:25 41:21	event 46:14	filling 38:12	g 3:5 46:2
doing 38:4	evidence 33:22	find 10:24 22:24	gain 25:12
donovan 39:5	exacerbation 21:8	finding 24:9,14	general 3:6 46:2,4 46:19
doubting 44:25	exam 2:12 11:8 17:13 26:9 28:12,19 29:16,22 36:7	findings 13:10 23:12 30:24	generation 44:12
dr 1:4 2:7,13 3:4 4:4 6:25 16:5,11,18,21 17:2,9 39:5,22 44:24 46:7	examination 2:8,9 2:10 4:9 33:11 37:3 44:2	fine 45:23	generator 30:11
drive 1:9	examined 4:6 10:23	first 4:5 6:15 7:3,24 22:8 24:4 28:20,25 33:6 34:2 46:8	gentleman 7:8 13:22 13:25
duly 4:5 46:3,8	excellent 31:6	fix 40:20 42:12	getting 11:20 32:17 41:22
duties 45:9	excludes 42:21	fixing 16:2	give 15:15
duty 17:10 29:3 37:13,17 38:3,6	excuse 20:18	flare 21:9	go 15:16 45:6
e	exhibit 4:1 16:20 17:2,3,11 19:10 26:14,15,16 27:12 28:1 33:11 44:25	follow 26:2 27:1,7 27:23	goes 43:16
e 1:12,12 2:1 46:1,1	exhibits 2:11	followed 30:14	going 15:14,16,24 16:19 19:9 26:13,17 37:5 38:24 41:21 42:6,6 43:24
	expert 35:15	follows 4:6	good 11:3 32:6 41:23
	extensive 14:8	foot 31:11	gotcha 16:4 35:2,5 44:16
	extent 10:9	foregoing 46:10	
		form 3:13 23:14 38:16	
		forms 38:11	

gotten 9:25 32:18 grade 18:17 grimminger 3:5 46:2 gross 18:14 guess 7:8,22 8:12 9:11 10:8,14 11:6 16:5 21:17 25:23 30:18 39:21 guessing 20:23 guys 25:10	huh 5:19 11:24 13:7 15:21 17:19 19:20 26:20 28:15 37:8 38:19 39:23 hurd 1:16 hurt 9:25	intact 11:2 interested 46:14 invalid 20:8,15 involved 45:11 iowa 5:21 issue 43:19	33:20 36:9,19 38:4 39:1,5,9 41:23 45:12 known 12:19 knows 10:4 kreshel 6:25
h	i	j	l
h 4:14 half 33:17 hand 46:16 happen 8:25 happened 10:21 happenstance 10:5 hardening 27:5,13 27:17 heal 23:7 24:1 healing 23:5 heard 7:17 41:21 heat 40:13 heavy 20:5 45:7,11 45:15 heels 31:3,10 help 22:21 43:12,13 helped 30:3 40:5 helpful 38:3 hereinafter 4:5 hereof 3:8 hereto 3:3 hereunto 46:15 herniated 23:14,23 herniation 13:15 34:25 hesitancy 33:16 high 18:16 hips 31:19 history 7:5,11,14 hoey 1:13 hoping 25:12	idea 40:10 identification 4:3 identified 35:15 identify 39:16 illinois 1:15 imaging 29:22 impaired 23:9 impose 15:20 impression 45:10 improve 44:14 improved 31:23 32:1 33:8 improvement 26:7 incisions 10:25 increased 21:7 24:10 increasing 21:5 indefinitely 38:17 independent 6:7 indicate 32:5 indicates 13:19 individual 14:21 induced 14:18 inflammatories 27:3 38:22 information 7:10 8:8 9:1 26:8 injections 31:2 injured 23:19 injury 10:11,19,21 23:2,6,11,17,20 40:14 innervation 23:6 40:11,15 43:22 instabilities 18:15 instability 13:20 14:10 18:17	j 1:13 james 1:16 3:12 january 45:7 job 1:25 2:14 9:23 9:25 10:8 20:4 29:2 36:16,16 37:12,23 38:5 45:13 john 19:4,15 22:3 joint 40:14,16 43:23 joints 14:12 29:24 29:25 40:11,12,19 43:18 july 19:6,6,8 20:18 22:3,5 24:20 25:16 jumped 20:13 june 6:17,25 7:11,24 9:8 10:24 11:23 12:17,18 13:9 15:3 16:25 18:18,22,24 19:2,6,7,12 20:18 22:8 25:22 28:20 34:2,7,23 35:3,6	l 3:1 4:14 l2/3 8:24 13:1 l3/4 8:22,23 12:24 13:2 34:1,25 l4/5 12:24 l5 8:24 12:24 22:2 22:25 34:1 labor 45:11 lack 31:24 language 45:5 lateral 31:10 leave 41:20 left 11:5,14,15 leg 11:15 legs 9:11,12,19 31:18,20 lesion 30:11 letter 6:25 7:11 11:23 31:6 44:6,24 level 13:19 20:4 25:25 29:2,7 37:12 37:17 42:4 43:5,6 levels 7:9 12:25 13:2 13:4,6,14,14,15,19 29:25 42:7 licensed 5:17 lift 18:4 lifting 9:20 light 29:3,7 37:13,17 38:3,6 limitations 11:21 36:10 limited 9:20 11:18 29:9 limiting 32:3 lincoln 1:18 16:6 46:17
		k	
		keep 16:2 26:13,17 keith 1:4 2:7 3:4 4:4 4:13 46:7 kind 5:12 12:8 14:10 26:11 32:15 kinds 23:12 knee 7:25 knew 10:3,7 know 5:24 8:17,25 13:2 14:20 15:16 16:7,9 21:2,9,20 23:22 24:6,8 25:2,3 26:1 27:6,13,22 30:15 32:14,22 33:3	

[line - okay]

Page 5

line 11:20	marrow 13:13	mrjs 34:4,11,18	notary 3:7 46:3,19
lisa 3:5 46:2	matter 18:1	35:11	note 2:12,13 6:18,19
list 5:13	maximum 26:6	muscle 18:13	6:21 15:10 16:21
listed 10:13	mcmahon 1:13 2:9	n	17:2 19:15 21:21
little 8:5 13:18 18:15	17:5 37:4 45:19	n 1:12 2:1 3:1	22:3 37:6 38:14
43:21,23	mean 12:16	name 4:12 6:4	39:10
llp 1:17	meaning 11:2 13:13	narcotics 27:2	noted 28:12 34:4
load 45:7	13:17 23:1,3,7,22	nature 23:16 42:11	notes 28:8 33:1
located 31:16	meant 13:2 43:2	near 31:7	notice 3:10
location 9:2 22:20	measure 29:13	nebraska 1:1,10,18	november 30:19,20
22:23	mechanical 31:15	4:17 5:18 46:5,17	31:5 32:23 38:14
lodhia 1:4 2:7 3:4	32:9,11 41:9,16	necessarily 20:9	39:10 44:5
4:4,13 46:7	42:12,17	40:24 42:23	numb 40:14
long 5:12,14 14:17	medical 2:15 7:5,16	need 29:3 37:13	number 26:14
14:23 15:16,23	12:13 26:7 44:19	38:25	
37:10 39:1	medication 32:16	needed 16:1,2 38:15	o
longer 30:3 40:23	36:10	38:16	o 1:17 3:1 4:14
look 6:15 11:7 12:3	medications 30:9	nerve 4:24 22:18,19	oath 4:7
16:14 22:18 25:13	32:20 38:16,25	22:20,23 23:7,13,15	objections 3:13
27:10	medicines 27:3	23:22,23 24:1 31:14	objective 33:22
looked 8:22 11:1	38:22 39:2	32:2 39:14,18 41:15	objects 18:5
12:24 14:21 22:8	mention 42:2	43:19,22,22 44:10	obviously 9:17
looking 26:14 27:11	mentioned 8:23	nerves 32:12 39:1	11:18 19:15 29:11
looks 6:23 7:17 11:1	12:10 35:3	40:13,19 41:2 42:18	43:12
12:17 25:7 31:19	merit 3:5	neurologically 11:2	occasionally 18:9
lot 13:12,20	michigan 5:21	neurosurgeon 5:2	occurring 23:6
low 32:10,11 40:5,8	middle 5:9	5:15	october 1:10 39:24
lower 13:21	midwest 1:9	neurosurgeries 4:23	46:17
luers 1:16,16 2:8,10	mild 14:12 24:15,16	neurosurgery 1:9	offered 42:5
3:12 4:10 17:6,8	mine 10:4	4:21,24	offhand 26:1
44:3 45:18,20	minor 21:10	never 45:3	office 6:13 9:7 16:11
lumbar 7:20 13:21	minutes 31:11 33:19	nevertheless 14:16	officially 46:16
22:21 31:8,24	33:21	new 21:16 23:5,6	oh 19:11
m	moment 22:4	newer 40:10	okay 6:23 7:19
madonna 25:1,2,6	months 8:21 10:18	noble 2:13 16:5,18	10:17 11:9 13:5
26:21 27:5	movement 37:22	16:21 17:2,9 44:24	14:15 18:18 19:9
making 39:11	mrh5 27:12	noble's 16:11	20:7,17 21:18 22:1
manage 38:23	mri 7:18 9:1 11:13	nonnarcotic 27:3	23:3 24:6,11,16
management 39:12	11:16 12:16,18,21	nonoperative 25:24	25:10,18,23 28:1,5
manager 39:15	12:23 13:8 14:21,25	normal 14:11	28:24 30:13 32:25
march 34:13,15,17	17:13 18:14 21:13	nos 4:1	33:15,20,24 34:14
34:18,23 35:12	21:24 22:5,7,13	notable 11:3	34:20 35:2,14,20
marked 2:11 4:2	30:24 32:13 34:6,11	notarial 46:4,16	37:16 38:7 41:14
16:20	34:15,22 35:6 36:8		42:24 43:11

Page 6

[old - realtime]

old 14:1 22:19 23:2 23:3 olds 14:4 omaha 1:10 4:16 once 15:7,24 one's 30:9 ongoing 14:17 23:5 operations 23:25 opinion 10:20 36:14 36:14 44:17 opinions 36:2,3,24 opposed 7:15 14:17 25:24 31:14 option 39:20 oral 5:6 order 11:25 15:4,18 19:12 ordered 12:4 15:1 21:12 orders 12:6 original 3:11 outside 3:17	part 5:6 11:23 19:9 40:18 particular 6:24 7:23 8:13 13:10 14:2 15:4 17:11 21:7 30:22 35:17 36:16 parties 3:3 party 46:13 pass 20:15 passed 5:7 patient 6:3,7 7:15 7:18,25 8:8 10:24 15:5,24,25 17:10 24:25 patient's 8:3 patients 8:5 16:8 40:21 41:14,17,21 42:22 people 24:18 27:23 40:24 42:15 perform 33:12 performed 41:8 period 16:3 peripheral 4:24 22:20 permanent 35:24 36:4,20 40:20,23,23 40:25 42:11,12 personally 16:7,10 peruse 17:12 phenomenon 23:21 phone 21:21 30:19 physical 2:16 10:8 17:13 20:3 23:22 25:3 26:9 27:1 28:12,19 29:16,22 31:21 33:13 36:7 45:11,12,16 physician 4:18 physician's 24:19 physicians 35:16 picture 6:8 pinched 22:20 pinching 23:14	pinpoint 44:10 place 3:7 15:5 46:11 placed 38:21 plaintiff 1:3,13 plan 11:23 26:25 39:12 planned 27:18,20 please 4:12 point 8:12 10:7 11:19 20:12 23:19 25:12 26:24 27:4,19 28:11 29:20 31:22 32:5,14 44:20 portions 40:18 43:22 position 10:20 possibly 11:19 24:5 30:2 posterior 13:17 postoperative 13:24 potentially 42:9 pounds 18:6,7,8,8 practicing 5:15 prescribe 15:4 32:19 38:6 prescribed 16:3 32:16 prescription 32:15 presence 3:17 presume 4:25 pretty 28:19 previous 7:9 8:17 10:14 22:1 previously 23:25 print 8:6 21:22 printed 8:4,4 printout 8:2 prior 7:6 35:11 probably 6:18 8:20 12:20 13:15 15:13 20:22 23:20 38:24 39:8 problem 16:1 problems 8:14	procedure 39:21 40:10,17 41:24 42:16,21,25 43:4,7 43:8 44:7 process 5:7 23:8 program 27:6,14 provide 16:19 provided 7:6,12,15 16:10 public 3:7 46:3,19 pull 18:5 purpose 9:8,14 22:16 28:5 pursuant 3:9 push 18:5 put 28:1
p		q	
p 1:12,12 3:1 p.m. 1:10 45:24 pa 19:1,3,16 page 2:2 3:8 16:24 19:10 27:11 28:25 pain 9:11,18 11:15 18:2 20:10,25 21:5 21:7,16 22:14,15 24:10 29:2,6,9,11 29:22,24 31:8,11,24 31:25 32:10,11,15 32:16,20 37:12,15 37:16,25 38:4,22,24 39:12,14,15,19 40:5 40:8,15,16,17,22 41:9,16,21 42:9,13 42:17 43:18 44:11 44:12 painful 40:11 paragraph 27:13 28:25		qualified 46:3 quantify 22:21 questions 37:2 quick 27:10 quickly 17:12 44:23	
		r	
		r 1:4,12 2:7 3:4 4:4 4:13 46:1,7 radicular 28:14 radiculopathy 22:2 23:1 radiofrequency 30:11 railroad 10:4,5,12 17:10 35:18 38:8 railway 1:5 raman 4:13 rate 13:8 35:21 41:24 read 11:22 19:14 27:5 45:21 real 34:16 realize 28:21 really 13:14 18:14 24:6 realtime 3:6	

[reason - snowden]

Page 7

reason 22:14 33:21	related 37:14 44:10	reviewing 9:1	29:23 30:19 34:6,12
recall 6:8,11 7:4	relative 46:13	rhizolysis 30:2,10	35:11 41:17
8:17 10:1 12:3	release 16:22	31:1,7 39:25 40:1,2	seeing 6:9 17:7
15:11,12 17:7 25:11	released 17:9	40:7 41:7,18,22	seeking 9:13
26:3 38:11 45:17	relief 9:13 38:17	42:16,21 43:10,13	seen 12:20 14:25
recollection 6:7	40:25 41:23 43:5	43:20	15:24 16:8,15 17:3
recommend 11:9	relieving 40:17	rhizotomy 30:4	17:23 20:20 30:25
26:9,10 29:19 44:5	remarkable 11:8	right 5:22 6:1,11,17	32:22 44:16,25 45:3
44:7	remember 7:4,19	6:18 7:3,23 8:14	semi 40:23
recommendation	10:2	10:10,23 11:5 13:25	sending 39:15
38:20	render 10:20 36:3	16:4,9,17 17:1,8	sensation 11:3
recommendations	rendered 36:2,14	18:3 19:21,23 20:1	sensory 40:18 41:4,6
37:7	reoccur 41:23	20:11,18 21:1,12,14	sent 6:24 24:25
recommended	repaired 35:5	22:2,9,11,15,25	25:11
11:16 26:4 27:2	repeat 22:5 41:24	24:23 26:17 27:19	separate 7:16
30:1,13 35:23	repetitive 37:22	29:11 31:9 34:16	september 28:4 29:1
recommending	report 7:21 9:5	35:7,21 36:19 38:10	37:6,19
11:13 26:25	13:10 25:5 26:4,19	38:13 39:7 40:6	service 25:17
record 8:3 25:13	29:1 32:4	42:1,20 43:11,16	set 3:7 17:11 46:15
recorded 5:25	reported 9:7 40:4	45:20,22	sheet 15:8
records 2:15,16 6:16	reporter 3:6,6	risk 41:8	short 15:15
7:16 12:13 16:11	reporter's 2:5	rmr 46:2	shoulder 8:1
18:23 26:2 42:2	reports 27:5	s	show 9:5 17:1 18:14
recurrent 34:25	requirements 36:11	s 1:12 3:1,1	19:9 21:25 25:5
redirect 2:10 44:2	residency 5:8,9	s1 8:24 12:24 28:13	showed 12:23 22:2
redo 8:21 12:10	resolution 31:8	34:1	22:25
reduce 29:6	response 4:7 31:7	saw 6:16,24 8:21	showing 13:4
reference 8:16	restrictions 15:4,6	13:20 14:1,2 18:23	signature 3:18
16:14 38:2	15:15,20,25 26:10	20:2,17,22 22:8	significance 12:22
referenced 15:9	26:11 35:24 36:4	28:3,7,20 33:7,7	significant 13:10,11
references 27:13	result 14:22 23:11	34:2,19,22,23 44:14	24:13 34:10,16 35:9
referral 39:4,11	23:18	44:23	significantly 14:3
referred 6:12 30:9	results 12:20 20:12	saying 10:2 29:5,8	22:7 32:1 40:5
reflect 26:2	21:19 22:13 34:6	says 7:20 9:10,15,16	44:13
reflexes 11:3 28:13	retrospndylolisth...	11:16 27:15 29:1	simple 14:23
regard 14:6 27:7,23	13:17 18:16	45:6	sir 4:20
44:17	return 16:22 36:15	scan 7:18 13:4	sit 6:2,6 33:2
regarding 16:22	36:16 41:10,17	scanned 16:15	sitting 33:17
regenerate 41:3,5,7	42:18	seal 46:16	situation 29:3 37:13
42:18	returned 41:16	second 27:12	37:18
regenerated 41:15	returning 17:15	secondary 5:7	six 5:16
registered 3:5	review 7:18 16:20	see 10:18 11:13	size 18:13
rehab 25:1,11,13	28:8 45:21	12:21 14:9,11 16:24	small 9:6
26:2 27:23	reviewed 28:7	19:23 21:20 22:6	snowden 1:16

solemnly 4:5	stretch 23:21,22	take 5:6,10 10:17	31:25 32:4,6 33:12
solution 30:3	strike 6:2 34:5	19:11 27:10,20 29:3	36:22 40:25 43:17
somebody 10:15	studies 32:13	30:14 32:21 33:5	44:22
32:19 39:16	study 35:1	40:10 45:5	thinking 43:16
something's 22:22	stuff 8:5	taken 1:5,9 3:5,9	thought 27:4 37:18
sorry 6:20 13:23	subjective 28:21	5:23 9:6 23:25 35:6	39:19
19:3 27:11 34:21	29:13	35:11 46:10	three 13:4,14,14
sort 7:5 43:3	subspecialties 4:22	takes 5:12	25:24 29:25 42:4,7
sounded 44:12	subspecialty 5:3	talk 9:17 45:14	42:8
source 29:24	success 41:24	talked 11:19 12:25	time 3:7,14 5:12
south 1:14	suffering 33:25	37:23	6:15 10:25 11:11,25
specialists 1:9	suggest 41:1	talking 6:9 17:21	16:3,16 17:14,22
specialty 4:20 5:5	suggested 19:18	20:11 22:3 28:9	18:7 21:13 24:10
specifics 10:2 45:12	suggesting 32:1	34:20 43:21	25:12 26:24 27:4,20
45:15	suit 46:14	target 44:11,11	28:2,11 29:20 31:1
specified 46:11	suite 1:9,14,18 4:16	tasks 17:10 18:4	31:22 32:5,14 33:6
spell 4:12	supers 10:6	33:13	33:7 34:2 35:6
spinal 4:23 38:18	suppose 28:8	tell 9:21,24 15:1	37:11 39:5,9,15
39:6,17	supposedly 40:24	16:17 17:12 21:18	41:19 44:9 46:10
spine 1:9 4:23,24	sure 21:10 29:21	34:9 46:8	tipping 13:18
5:5 7:20 13:21 14:3	33:14	telling 37:21	title 3:8
22:21	surgeon 16:19	temporary 35:24	today 6:2,6 26:11
spoke 18:24 24:20	surgeries 7:25 8:1	36:4,20	33:2
30:18	9:3 14:7 42:17	tend 15:17	told 12:14,16 32:10
spondylolisthesis	surgery 7:9,22 8:17	term 14:17,23 15:15	37:20 44:5,15 45:8
14:10	8:22 9:18,19 10:15	15:23 30:3 40:23	top 16:24
spur 23:24	11:12 12:8 13:16	terms 9:2 18:10	tops 41:1
stably 23:8	16:18,22 17:9 27:18	45:15	totally 43:24
stand 33:18	27:20 32:20 34:19	test 21:19	trace 18:15
standing 33:18	34:24 42:10,22	testified 4:6	transcribed 3:17,19
standpoint 31:21,23	43:25	testimony 3:16	45:21
state 4:11 5:17 46:5	surgical 12:23	46:15	trauma 14:22
stated 8:19 37:11	suspect 12:15 17:17	testing 20:3,12 36:8	traumatically 14:17
38:14	32:18 43:6	tests 20:16 21:21,22	treating 35:16
statement 2:14	sworn 4:5 46:8	thank 44:1	treatment 39:12
states 1:1	symptoms 9:17	therapy 2:16 25:4	41:18
stiff 9:20	11:15 24:4,18 28:14	27:2	truth 46:8,9,9
stimulator 38:18	31:3,14,15,16 32:2	thigh 11:5,6	trying 23:7 25:24
39:6,18	40:3 41:8,10,15	thing 9:17 21:7 30:7	twisting 37:22
stipulated 3:2	42:18 43:12,14 44:9	things 21:10 37:25	two 34:11,19,20
stipulations 2:4	44:12	38:1,2	41:1
46:12		think 5:24 9:22 12:2	type 14:16 15:2
street 1:17		12:4,25 13:1 14:24	17:15 23:10 37:22
strength 11:2 18:13		15:17 17:18 18:11	39:18 40:14 42:12
		21:23 25:6 26:18	

[types - years]

Page 9

types 33:12 typically 5:10 9:15 13:19 14:9 15:14,19 23:18 30:10 32:19 41:20 43:8,15	weighing 18:5 went 25:2 39:9 whereof 46:15 wife 24:20 william 1:13 wise 15:6 witness 2:6 3:16,17 3:18 35:15 45:23 witness's 4:7 wolfe 1:16 words 6:8 15:5 24:14 26:3 39:3 work 10:5 16:23 20:4 26:9,10 27:5 27:13,17 37:21 38:25 40:2,7 43:7 45:6 worked 10:3 written 5:7 wrong 29:4 wrote 44:24
u	x
u 3:1 uh 5:19 11:24 13:7 15:21 17:19 19:20 26:20 28:15 37:8 38:19 39:23 unchanged 28:12 undergo 42:15 understand 5:14 21:4 44:1 understanding 20:5 united 1:1 unreasonable 18:9 use 26:8 30:10 usually 8:3 9:16 18:16 30:9	x 2:1
v	y
verify 12:13 versus 22:19,19 vertebrae 13:18 virtually 29:17 visit 2:12 7:24 9:14 15:3 18:22 28:6 30:17,23 visits 16:16 vs 1:4	yeah 8:9,12 14:5 17:6,17 20:6 21:5 25:22 35:22 40:1 year 5:10,12 8:20 14:4 41:1 years 5:16 14:1 41:1
w	
waive 45:22,23 waived 3:19 walk 33:19,21 walked 31:11 walking 31:4 want 25:13 wanted 29:23 way 14:20 22:21 24:6 we've 32:20	

Exhibits



DANIEL P. NOBLE, MD
CHRISTOPHER M. MCWILLIAMS, PA-C

PATIENT: David Bliss
EXAM DATE: June 24, 2010
PRIMARY CARE PHYSICIAN: Charles Kreshel, M.D.

CHIEF COMPLAINT:
F/U left L3-4 microdiscectomy.

HISTORY OF PRESENT ILLNESS:
David returns today wishing to return to work. He feels better at this point than he has in a long time. He is doing better in all areas. He does feel he can return to work at this point without any heavy lifting.

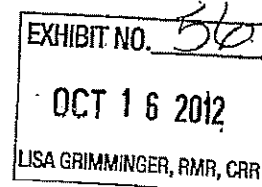
REVIEW OF SYSTEMS:
Unremarkable for any recent illnesses or other complaints.

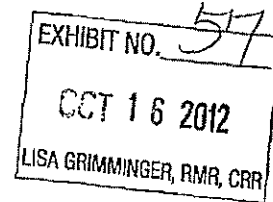
PHYSICAL EXAMINATION:
None today

DIAGNOSIS:
1. S/P left L3-4 microdiscectomy, DOS 5-6-10
2. S/P left L4 laminotomy with lateral recess decompression and discectomy, DOS 2-10-03

RECOMMENDATIONS:
1. Return to work. The patient may return to duty effective 6-25-10 with restrictions as outlined on his return to work form. Restrictions remain in place until 11-6-10.
2. MMI. I do expect he will be at MMI 11-6-10.
3. Return to clinic 8-12-10.

Daniel P. Noble, M.D./ap





DR. Noble:

David Bliss, regarding: Dr. Noble today is the 17th of June. I stopped into my employer yesterday as regards to my status.

My job is Carman relief write up. So here's what happens, 90% of the time I write up bills for the repair of rail cars. This is walking around cars and most the day at a desk and computer. The relief part is to fill in for men on vacation or sick eat there are 8 of these guys and all have 5 weeks vac. and 1 is currently out due to an accident I am one of 2 men who know the different write up positions, for each does it different due to different types of cars. I'm needed rarely more than likely I won't see any carman work until at least Jan. of 2011 and then it's not a heavy load. BNSF has a med dept. They are some on restrictions I sattey rule is were not to lift anything over 50# without assistance. I won't have to go there anyway. Please could you give me a medical release to go back to work I am off all pain meds, and feel good strength is back in my leg please call 575-1110.

NSC00158

AUG-05-2010 20:37 From: 4024846625

Page: 2/2

Aug. 4. 2010 12:58PM BNSF RAILWAY

No. 6457 P. 1



Medical and Environmental Health Department

ATTENTION PROVIDER

Due to the work level of the position held by this employee and/or the nature of his condition, please complete this brief form and fax back to BNSF at 888-488-1260. Thank you.

**Statement of Job Awareness
General Job Duties
Carman**

EXHIBIT NO. <u>58</u>
CCT 16 2012
LISA GRIMMINGER, RMR, CRR

TO PROVIDER:
Re:

Dr. Daniel Noble MD
David Bliss 6/21/1935

Some of the physical requirements of the position include:

- **Must be able to make quick hand and leg movements** -- Due to the nature of the position, i.e. working around moving and heavy equipment, it is imperative that an individual is aware of the environment and able to respond quickly to any unsafe condition.
- **Perform car and equipment inspections** -- Requires an individual to proficiently walk on uneven terrain and ballast to inspect for any unsafe conditions or mechanical defects.
- **Climb on/off equipment** -- This involves lifting one foot approximately 3 ft. onto a ladder while reaching up to grasp the grab irons with both hands and pull their weight up onto the ladder.
- **This carman maintains, replaces and/or repairs air brake pipes, valves or fittings, gaskets, air hoses, and other equipment as required to maintain a safe train.**
- **The carman must be able to exhibit physical strength sufficient to lift/carry push and pull objects weighing between 25 pounds (frequently) to 50 pounds (occasionally); pull, push, and position equipment or car components when making repairs; occasionally move rail car wheels; bend stoop occasionally as required when making repairs to freight cars; climbing onto and off of rail cars; maintain balance while climbing on stairs or ladders to repair rolling stock; perform occasional overhead work, remain standing or sitting for more than 1/2 of every work day with the opportunity to periodically change positions for comfort. Some work is performed in below ground workspaces to access undercarriage of rail car.**
- **The employee must be able to stoop, bend and twist low back on occasional to frequent basis; must be able to kneel, crawl and crouch on occasional to frequent basis; must be able to walk on angled and uneven ground; must be able to climb and work at elevations > 12 feet above ground level; must be able to remove and replace components on rolling stock (shoes, coupler assemblies, air brake systems), use power tools and non power tools, and conduct inspections of rolling stock (railroad cars) in a yard or on a track.**

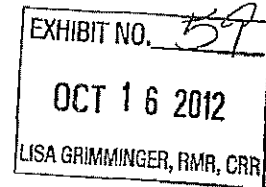
I have considered the above job responsibilities in reaching my professional opinion regarding this employee's medical condition and capability to work.

DANIEL NOBLE, MD Daniel Noble 8/5/10
Physician's Printed Name and Degree Signature Date

09/26/2011 09:57:43 AM

Remote ID ->

Page 14 / 29



8006 Farnam Drive, Suite 305
Omaha, Nebraska 68114
ph: (402) 398-9243
fax: (402) 398-9253

Account #: 104758
Requesting MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68621
(402) 476-9107
06/21/1966

6/8/2011

Dear Dr. Kreshel:

David Bliss is here in the neurosurgery clinic in consultation. Mr. Bliss is a pleasant 55-year-old who had recent surgery in April including redo discectomy at L3-4. He has had previous discectomy at L3-4 as well as what appears to be one at L5-S1, although he says he thought it was L2-3. He has had some pain in his legs and back before surgery. After his last surgery in April he has really had a hard time bouncing back. He has a lot of mechanical back pain. He has had atrophy in his left leg, although it is improving with physical therapy significantly. He has noticed a lot more pain in his back. He is achy and stiff and has limited lifting because of this. He has no numbness. He does have some quadriceps atrophy and weakness overall he says.

The patient is alert, oriented times three and appropriately dressed with normal affect. The neck is supple without masses. Casual gait is symmetrical, with normal heel-toe progression. Heart has regular rhythm, with no murmur. The lungs are grossly clear to auscultation. No carotid bruit is heard. The lower extremities demonstrate normal strength, reflexes, sensation and muscle tone bilaterally. He has mildly decreased muscle bulk when looking at his left thigh compared to his right thigh. No joint instability or crepitus is noted in the lower extremities exam. Patrick's maneuver bilaterally is negative. Straight leg raise is negative bilaterally. Dorsalis pedis and posterior tibialis pulses are regular and full bilaterally. There is no lower extremity edema. There is no clonus at the ankles bilaterally, and Babinski reflexes are absent bilaterally. Range of motion of the spine is full without increased pain. Palpation of the spine is nontender, although he has 2 well healed lumbar dorsal incisions in the midline from his spine surgery.

Imaging was reviewed including MRI of the lumbar spine from 3/18/11. This was preoperative before his last L3-4 discectomy. There is evidence of recurrent disc herniation at L3-4 with compression to the L3 nerve root. There are modic endplate changes at L3-4 significantly. There are also some endplate changes and disc degeneration at L4-5. There is disc bulging, but no significant nerve root compression. At L5-S1 there appears to be a laminotomy on the right.

MNASS00014

Page 2 - David R Bliss

There is facet arthropathy severe at L5-S1 and some foraminal stenosis on that right side compared to the left, though both sides are having foraminal stenosis. There is also facet arthropathy at L3-4 and L4-5 that is more minimal. There is hypertrophy of the facets at L3-4. There is a slight posterior spondylolisthesis at L3-4. The remaining discs appear fairly normal.

ASSESSMENT:

1. Lumbar posterior spondylolisthesis L3-4.
2. Lumbar spondylosis L5-S1, L3-4 and L4-5.
3. Previous laminotomies, discectomies.
4. Disc degeneration.

PLAN: David has continued mechanical back pain. I believe with his job on the railroad he is going to be somewhat limited given his multiple history of disc degenerations. He has not had any recent imaging. We will get an MRI of the lumbar spine. I discussed operations including discectomy and fusion. We discussed limitations with and without surgery as well. At this point he would be a candidate for a functional capacity evaluation to see what his level of ability is. We will get him set up for his studies, and I will contact him with the results.

Sincerely,



Keith R. Lodhia, MD

Dictated but not proofread

09/25/2011 09:57:43 AM

Remote ID ->

Page 16 / 29

Charles L. Kreshel MD
3100 N 14th St STE 201
Lincoln, NE 68521-2134

RE: David R Bliss
Account #: 104758
DOB: 06/21/1955
Exam Date: 06/08/11
Ordering Physician: Keith R. Lodhia, MD
Referring MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD

Dear Dr. Kreshel:

MAGNETIC RESONANCE IMAGE OF THE LUMBAR SPINE WITH AND WITHOUT INTRAVENOUS CONTRAST

CLINICAL INDICATION: Low back pain, leg pain.

TECHNIQUE: Sagittal and axial pre and post contrast T1 weighted images and also T2 weighted FSE images of the lumbar spine were obtained. 20 cc of Magnevist contrast to the normal technique.

FINDINGS: Evaluation of the lumbar spine demonstrates a trace of retrolisthesis of L3 on L4. There is noted to be end plate degenerative marrow signal changes at the level of L3-4, L4-5 and L5-S1. No evidence to indicate fracture. The conus medullaris ends at the level of L1-2 and demonstrates normal signal. The visualized sacrum and SI joints are noted to be normal.

At L5-S1 the disc space demonstrates postoperative changes of right hemilaminectomy change. There is a diffuse disc bulge. There is a mild end plate osteophytic ridge. The facet joints demonstrate moderate hypertrophic change. There is mild bilateral foraminal stenosis. No central canal stenosis.

At L4-5 the disc space demonstrates decompressive right and left laminectomy change. The disc space demonstrates mild to moderate loss of height. There are end plate erosions. There is vacuum phenomenon. There is a diffuse disc bulge with an end plate osteophytic ridge. Disc and osteophyte extend into both the right and left foramen. There is moderate left and mild to moderate right foraminal stenosis. No evidence for central canal stenosis. The facet joints demonstrate mild hypertrophic change.

At L3-4 the disc space demonstrates decompressive left laminectomy change. There is a diffuse disc bulge with an end plate osteophytic ridge. There is a focal area of disc protrusion extending to the left paracentral aspect of the canal. This is best viewed on sagittal image #9 and axial image #9. This is effacing the left side of the thecal sac. This is surrounded by areas of granulation tissue. There is no underlying central canal stenosis. No significant foraminal narrowing. The facet joints are mildly hypertrophic.

RE: David R Bliss

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
402.390.4100
fax: 390-4103

Bruce Baron, DO
Christian Schlaepfer, MD
Erik Pedersen, MD
Don Evans, MD

MNASS00016

09/26/2011 09:57:43 AM

Remote ID ->

Page 17 / 29

Account #: 104758
DOB: 06/21/1955
Exam Date: 06/08/11
Page 2 - Lumbar MRI

At L1-2 and L2-3 the disc spaces are normal. There is no central or foraminal stenosis.

IMPRESSION:

- 1) Small left paracentral disc protrusion at L3-4. Correlate clinically with symptoms.
- 2) Bilateral foraminal stenosis greater on the left than right at L4-5.
- 3) Mild bilateral foraminal stenosis at L5-S1.
- 4) No central canal stenosis.
- 5) Facet hypertrophic changes of the lower lumbar spine.

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
402.390.4100
fax: 390-4103

Thank you for the courtesy of this referral.

Sincerely,



Christian Schlaepfer, MD

CS/ mw

Dictated at Midwest NeuroImaging, 68114, 06/08/2011

Bruce Baron, DO
Christian Schlaepfer, MD
Erik Pedersen, MD
Don Evans, MD

Electronically approved by: Midwest NeuroImaging Date: 06/09/11
09:43

MNASS00017

09/26/2011 09:57:43 AM

Remote ID ->

Page 13 / 29

- 1 -

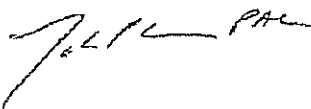
Account #: 104758
 Requesting MD: Charles L. Kreshel MD
 Family MD:
 Case Manager:

David R Bliss
 1801 Preamble Lane
 Lincoln, NE 68521
 (402) 476-9107
 06/21/1955

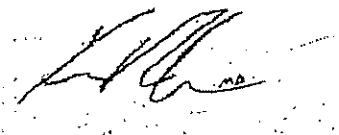
June 13, 2011

I spoke with Mr. Bliss in regards to his MRI scan showing multi-level degenerative facet changes. He has a disc herniation which was smaller than previous surgery in April. Dr. Lodhia did feel that he would be a surgical candidate consisting of a lumbar fusion L3-4, L4-5 and L5-S1.

At this point he seems to be getting by. Dr. Lodhia has recommended a functional capacity evaluation for further evaluation of his current work status. Mr. Bliss will give us a call once this has been completed.



John P. Calabro, PA-C



Keith R. Lodhia, MD
 JC/KRL: mw
Dictated but not proofread

MIDWEST NEUROSURGERY

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 Omaha, Nebraska 68114
 Phone: 402.398.9243
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201 Ridge Street, Suite 305
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Leslie C. Hellbusch, MD
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 Stephen E. Doran, MD
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 Wendy J. Spangler, MD
 Bradley S. Bowdoin, MD
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 Guy M. Music, MD

Julie Walsh, PA-C
 Charley Pugsley, PA-C
 Michele (Shelley) Julin, PA-C
 John Calabro, PA-C
 David Siebels, PA-C
 Kim Nelson, PA-C
 Brittany Lancha, PA-C
 Kristin Hennessey, PA-C

John Dunn
 Clinic Administrator

Electronically approved by: John Calabro Date: 06/16/11 15:33

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
 Omaha, Nebraska 68114
 Phone: 402.390.4100
 Fax: 402-390-4103

MNASS00013

09/26/2011 09:57:43 AM

Remote ID ->

Page 9 / 29



8006 Farnam Drive, Suite 306
Omaha, Nebraska 68114
ph: (402) 398-9243
fax: (402) 398-9253

Account #: 104768
Requesting MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1966

07/13/2011

David Bliss is here today in followup and consultation after undergoing functional capacity evaluation. Mr. Bliss reports having increasing back and leg pain along with numbness into the balls of his feet. We had previously evaluated him and found his multi-level degenerative change along with multi-level previous surgeries. We had recommended the possibility of an L3 through S1 lumbar fusion. Due to his increasing pain, we are seeing him for further evaluation.

He is alert, oriented times 3, affect was appropriate. Gait was antalgic with a leaning wide based stance. He has mild decreased bulk into the left thigh as compared to the right. Motor strength is considered about a 5. Sensation is decreased in non dermatomal pattern. He has no clonus and Babinski reflexes are absent. Straight leg raise causes lumbar back pain. He has a well healed lumbar incisional site.

ASSESSMENT: 1) Bilateral lower extremity pain and lumbar back pain.

PLAN: David Bliss presents today with worsening symptoms. We have recommend proceeding with EMG studies of bilateral lower extremities along with a repeat MRI of the lumbar spine for further evaluation. Mr. Bliss now reports pain in the S1 distribution which is increased in intensity since previous examination. Therefore we will repeat his MRI scan. We did briefly discuss surgical intervention consisting of a lumbar fusion L3 through S1. We will plan on seeing him back once the studies have been completed to further discuss treatment options.

John P. Calabro, PAC

Keith R. Lodhia, MD

Dictated but not proofread

09/26/2011 09:57:43 AM

Remote ID ->

Page 11 / 29

Charles L. Kreshel MD
3100 N 14th St STE 201
Lincoln, NE 68521-2134

RE: David R Bliss
Account #: 104758
DOB: 06/21/1955
Exam Date: 07/13/11
Ordering Physician: Keith R. Lodhia, MD
Referring MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD

Dear Dr. Kreshel:

MAGNETIC RESONANCE IMAGE OF THE LUMBAR SPINE WITHOUT CONTRAST.

CLINICAL INDICATION: Bilateral leg pain, greater on the left than right, back pain.

TECHNIQUE: Sagittal and axial T1 and T2 weighted FSE images of the lumbar spine were obtained./

FINDINGS: Evaluation of the lumbar spine with comparison to prior examination from 06/08/11. The lumbar spine demonstrates the alignment to remain stable since prior examination. There is a trace of retrolisthesis of L3 on L4. Vertebral body heights demonstrate no areas of new marrow signal abnormality to indicate tumor or infection. There is extensive end plate degenerative marrow signal changes at the level of L3-4, L4-5 and L5-S1. The sacrum remains stable in signal. No new abnormality of the SI joints.

At L5-S1 the disc space demonstrates postoperative changes of right hemilaminectomy change. The disc space demonstrates disc space desiccation. There is a diffuse disc bulge and end plate osteophytic ridge. The facet joints demonstrate moderate hypertrophic change. The appearance of the disc is noted to be similar to prior examination. There is mild bilateral foraminal stenosis. There is no new area of central canal stenosis.

At L4-5 the disc space demonstrates post surgical changes of bilateral laminectomy change. The disc is demonstrating moderate loss of height. There are end plate erosions. There is a diffuse disc bulge and end plate osteophytic ridge. This extends into both the right and left foramen. There is moderate left and mild to moderate right foraminal stenosis. The appearance remains stable. The facet joints are hypertrophic. No new area of central canal stenosis.

At L3-4 the disc space demonstrates postoperative changes of left hemilaminectomy change. There are elements of granulation tissue seen along the thecal sac. The disc is narrowed with a diffuse disc bulge. The small area of disc protrusion within the granulation tissue is noted to be similar to smaller than on prior examination.

RE: David R Bliss

MIDWEST NEUROIMAGING

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Bruce Baron, DO
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Don Evans, MD

MNASS00011

09/26/2011 09:57:43 AM

Remote ID ->

Page 12 / 29

Account #: 104758
DOB: 06/21/1955
Exam Date: 07/13/11
Page 2 - Lumbar MRI

Disc and osteophyte extend into both the right and left foramen. There is noted to be mild inferior foraminal stenosis, similar. There is no new central canal stenosis.

At L1-2 and L2-3 the disc spaces are noted to be normal. There is no underlying central or foraminal stenosis.

IMPRESSION:

- 1) Bilateral foraminal stenosis greater on the left than right at L4-5, stable.
- 2) Mild bilateral foraminal stenosis at L5-S1, stable.
- 3) No new central canal stenosis.
- 4) Post surgical changes at L3-4, stable.

Thank you for the courtesy of this referral.

Sincerely,



Christian Schlaepfer, MD
CS/ mw

Dictated at Midwest NeuroImaging, 68114 07/13/2011

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
402.390.4100
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Bruce Baron, DO
Christian Schlaepfer, MD
Erik Pedersen, MD
Don Evans, MD

Electronically approved by: Midwest NeuroImaging Date: 07/14/11
09:29

MNASS00012

JOHN C. GOLDNER, M.D.
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Neurology

Consultation • Electromyography

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INDIAN HILLS MEDICAL PLAZA • 8901 WEST DODGE ROAD, SUITE 210 • OMAHA, NEBRASKA 68114-3442

ELECTROMYOGRAPHY / NERVE CONDUCTION STUDY REPORT

NAME: David Bliss	DOB: 6/21/1955	FILE #: 2011-2014
PHYSICIAN (S): Keith Lodhia, M.D.	DATE: 7/13/2011	

NERVE CONDUCTION STUDY:

MOTOR:

<u>Nerve</u>	<u>Stimulating</u>	<u>Recording</u>	<u>Distal Latency (insec)</u>	<u>Proximal Latency (msec)</u>	<u>Amplitude (N=Normal)</u>	<u>Distance (cm)</u>	<u>Conduction Velocity (m/sec)</u>	<u>Normal (m/sec)</u>
Lt. Peroneal	knee-ankle	ext. dig. brevis	5.3	14.5	N (3.9/3.4)	9/41	46	38-65
Rt. Peroneal	knee-ankle	ext. dig. brevis	5.7	14.3	N (4.0/4.5)	9/39	45	38-65
Lt. Tibial	knee-ankle	abd. hallucis	5.7	14.1	N (7.1/5.9)	9/42	50	38-65
Rt. Tibial	knee-ankle	abd. hallucis	5.6	15.0	N (8.3/8.1)	9/41	44	38-65

SENSORY:

<u>Nerve</u>	<u>Stimulating</u>	<u>Recording</u>	<u>Latency</u>	<u>Amplitude (N=Normal)</u>	<u>Distance</u>	<u>Normal</u>
Lt. Sural	posterior aspect lower leg	lateral malleolus	2.8	N	14	

ELECTROMYOGRAM:

<u>Muscle</u>	<u>Fibrillation</u>	<u>Fasciculation</u>	<u>Motor Unit Potentials</u>
Lt. tibialis anterior	0	0	Normal
Lt. medial gastrocnemius	0	0	Normal
Lt. peroneus longus	0	0	Normal
Lt. vastus medialis	0	0	Normal
Lt. tensor fasciae latae	0	0	Normal
Lt. abductor hallucis	0	0	-
Rt. tibialis anterior	0	0	Mildly large, polyphasic motor units
Rt. peroneus longus	0	0	Mildly large, polyphasic motor units
Rt. tensor fasciae latae	0	0	Mildly large, polyphasic motor units
Rt. medial gastrocnemius	0	0	Normal
Rt. vastus medialis	0	0	Normal

EMG with nerve conduction studies of the lower extremities was done at the request of Dr. Lodhia on a patient with left more than right lower extremity pain and prior back surgeries.

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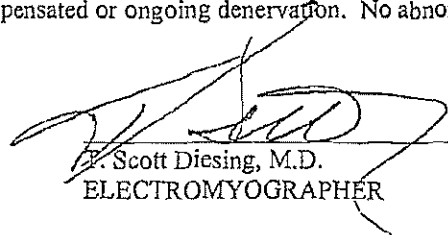
Neurology LLP
8901 West Dodge Road Suite 210
Omaha, Nebraska 68114-3442

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DAVID BLISS
July 13, 2011
PAGE TWO

SUMMARY: The peroneal compound muscle action potentials were normal and symmetric. The tibial compound muscle action potentials were normal and symmetric. The left sural sensory nerve action potential was normal. Needle examination of the left lower extremity was normal. Needle examination of the right lower extremity demonstrated mild chronic stable neuropathic motor unit changes within the right L5 myotome.

IMPRESSION: Abnormal EMG and nerve conduction studies of both lower extremities. There is electrophysiologic evidence of a mild chronic right L5 radiculopathy without evidence of uncompensated or ongoing denervation. No abnormalities were noted in the left lower extremity. Clinical correlation is needed.

 M.D.
Dr. Scott Diesing, M.D.
ELECTROMYOGRAPHER

TSD:pjf

Neurology LLP
8901 West Dodge Road Suite 210
Omaha, Nebraska 68114-3442

Neurology00002

09/26/2011 09:57:43 AM

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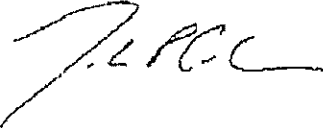
Page 8 / 29

Account #: 104758
Requesting MD: Charles L. Kreshel
Family MD: Charles Kreshel
Case Manager:

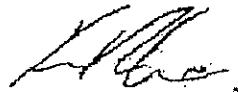
David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1955

July 15, 2011

I spoke with David R Bliss's wife in regards to his EMG study showing chronic radiculopathy. No new or acute changes. In regards to the MRI scan this shows three-level lumbar disk degeneration as previously noted. No new disk herniations or listhesis.



John P. Calabro, PA-C



Keith R. Lodhia, MD
JPC/KRL/lmh

Dictated but not proofread

Electronically approved by: John Calabro Date: 07/22/11 08:36

MIDWEST NEUROSURGERY

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Omaha, Nebraska 68114
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Wendy J. Spangler, MD
Bradley S. Bowdino, MD
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Guy M. Music, MD

Julie Walsh, PA-C
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John Calabro, PA-C
David Siebels, PA-C
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MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
Phone: 402.390.4100
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MADONNA REHABILITATION HOSPITAL

OUTPATIENT CLINIC NOTE ON: Bliss, David R

DATE OF SERVICE: 07/26/2011

REFERRING PHYSICIAN: Keith Lohdia, M.D.

REASON FOR REFERRAL: Rehabilitation evaluation and recommendations for chronic low back pain and left leg pain.

TIME IN: 2:00 TIME OUT: 3:15

Over 60 minutes were spent today with David and his wife, the majority of which was in evaluation, case discussion and management, and patient education.

HISTORY OF PRESENT ILLNESS: David Bliss is a pleasant 56-year-old gentleman who was referred here by Dr. Keith Lohdia for evaluation of low back pain. He has a fairly complicated history. In 2003, he underwent an L3-4 laminectomy due to a disk herniation that was causing a lot of left leg symptoms. It sounds like there was weakness in the left leg as well as possible footdrop and significant pain. He responded well to the surgery and had been working with the railroad since that time. This initial surgery was done by Dr. Noble. In the spring of last year, he started to develop similar symptoms going down the leg. He underwent a microdiscectomy in May with a follow-up exploration in April of this year. He still was having some ongoing symptoms and sought an opinion by Dr. Lohdia at Midwest Neurosurgery & Spine Specialists in Omaha. He reviewed the imaging studies and felt that it was primarily mechanical low back pain. They did repeat an MRI and discussed surgical options. He subsequently underwent functional capacity examination here in Lincoln around late June or the beginning of July. He tolerated the test pretty well but the following day was having an increase in his pain, not only the low back but also his left leg symptoms were worse. He saw Dr. Lohdia again who repeated the MRI and obtained electrodiagnostic studies that are discussed later.

After discussing the next surgical option which would essentially be a multilevel fusion, Dr. Lohdia referred David here for further evaluation and recommendations. Today he states that his pain is worse in the low back compared to the leg. He generally feels the best if he is lying flat on his back. Activity, especially frequent bending and lifting, bother him. He also has difficulty with lateral bending, especially to the left. He feels like he has general atrophy and weakness in the legs but that this has gotten somewhat better with physical therapy. He is working with Jeremiah Jurgensen here in town 2 times per week doing a variety of strengthening and stretches along with modalities. Currently for pain control he is primarily taking Tylenol frequently as well as some tramadol that is prescribed through his primary physician, Dr. Kreshel.

As this is work related, David is frustrated with the fact that his previous office job was no longer available after one of his surgeries and he has been doing more manual labor. He has not been back to work since his most recent surgery in April. Dr. Noble felt that it would take at least 3 months to get back to light to

MADONNA REHABILITATION HOSPITAL
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NAME: Bliss, David R
SERVICE DATE: 07/26/2011
PATIENT NUMBER: 3002210023
MEDICAL RECORD NUMBER: 13-30-81
PHYSICIAN: Adam T. Kafka, M.D.

193245 Page 1
Original

MRH00006

medium duty work and 6 months for medium to heavy. David does not feel like he is anywhere near ready to go back to his previously highly physically demanding job.

David's other concern is that he does have quite a bit of fatigue. He thinks it has been worse since his most recent surgery and is unsure whether it is related to the pain or therapy that he has been undergoing. He has had to cut back on social activities as he used to fish quite a bit on his bass boat but is unable to do this. His sleep has been affected as well.

PAST MEDICAL HISTORY:

1. He has asthma that is well controlled and not requiring medications.
2. History of severe GI bleed requiring transfusion. This was thought to be related to aspirin and Motilac.
3. ACL repair in 1998.
4. Laminectomy in 2003.
5. Microdiscectomy in 2010.
6. Microdiscectomy revision in May of 2010 and April of 2011.
7. Multiple knee arthroscopies.
8. Left shoulder arthroscopy.

FAMILY HISTORY: Both parents are deceased, his father of a heart attack and mother of diabetes. He denies any history of diabetes.

SOCIAL HISTORY: David is single but has a significant other. He has occasional alcohol but no tobacco or alcohol exposure. He does not get any regular activity outside of work. He was previously a car man for the railroad.

CURRENT MEDICATIONS:

1. Tylenol max dose daily.
2. Tramadol 2 tabs every 4-6 hours p.r.n.

ALLERGIES: NEOSPORIN causes rash and THEOPHYLLINE causes GI reflux. He is also sensitive to adhesives.

REVIEW OF SYSTEMS: Twelve-point review of systems was obtained today and positive for fatigue, mild asthma, and those complaints listed in the HPI. The remainder was negative.

PHYSICAL EXAMINATION:

GENERAL: David is a pleasant, well-appearing, moderately obese gentleman in no distress. He does not exhibit any pain behaviors but is clearly frustrated with his current symptoms and especially as it relates to his occupation.

HEENT: Head is normocephalic, atraumatic. Facies are symmetric.

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193245 Page 2
Original

MRH00007

SKIN: Warm and dry throughout.

EXTREMITIES: No swelling, erythema, or ecchymoses.

BACK: Multiple midline incisions all well approximated and healed. He has some flattening of normal lumbar lordosis. He has fairly good flexion and extension, neither of which is particularly painful, but he is weak with extension and has some difficulty getting back to upright posture. He does not have any obvious list or scoliosis. He has pretty good lumbar rotation but sidebending to the left is restricted and quite painful. He has tenderness around the left SI joint as well as lower lumbar facets. This pain is exacerbated by sidebending but not too much by extension. He has no gluteal tenderness or pain around the trochanteric region. Examination of the legs shows symmetric muscle bulk without any obvious atrophy. He has at least 4+/5 strength throughout, and I have difficulty eliciting any obvious strength deficit. He can heel and toe walk without difficulty other than a little bit of balance trouble.

NEUROLOGIC: Absent reflex at the left patella but 2/4 at the right. He has 1+ reflexes at the Achilles, but it seems a bit more diminished on the left compared to the right. Sensory examination to light touch and pinprick is normal to all right lower extremity dermatomes. In the left lower extremity he basically has decreased sensation throughout the entire foot. This is mainly to pinprick which feels more dull compared to the right side, but light touch is preserved. There is no clonus or upper motor neuron signs noted.

IMPRESSION: David Bliss is a 56-year-old gentleman with chronic low back pain, primarily mechanical and axial, with history of multiple lumbar surgeries. He also has radiating symptoms in the left lower extremity that have improved with therapy but persist and are in a nondermatomal pattern. Imaging studies show diffuse degenerative arthritis in the lumbar spine as well as spondylosis at L3-4, L4-5, and L5-S1 with small posterior spondylolisthesis at L3-4. This is based upon the imaging reports as I do not have the images available. I did review the electrodiagnostic studies obtained on 07/13/11 which show some large polyphasic motor units in the right L5 myotome but no evidence of ongoing axonal loss. Also no evidence of peripheral neuropathy or focal neuropathy.

RECOMMENDATIONS: We had a long discussion about possible etiologies of his pain and that this is likely multifactorial. I would obviously defer to Dr. Lohdia as to whether or not he would be appropriate for a fusion, but this may not be a bad option, especially with what appears to be some mild facet-mediated pain, especially on the left which is where the majority of his pain seems to be coming from. Nevertheless, I think an adequate course of physical therapy and some medication management would be reasonable as there is certainly no rush to undergo surgery.

To help with pain control, I was hoping to use antiinflammatories; but with his history of GI bleed, I am a little hesitant to start an oral agent. I have had some luck with Flector patches which have much lower incidence of GI ulceration and therefore gave him a few samples to try; and if the adhesive does not bother him, he can get this script filled. He should apply it to the left low back where the majority of his pain is. Additionally I would like to start him on Lyrica to help with his leg symptoms as well as overall pain modulation in the hopes that he has better baseline control and can cut back on the amount of tramadol that

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193245 Page 3
Original

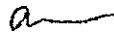
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he is using.

I did write a prescription to obtain a vitamin D level as low levels have been associated with fatigue as well as pain. Furthermore, this is easy to correct if it is low.

I would like to see him back in 1 month. We will assess how he is responding to physical therapy as well as medication management. It does not appear as though he is going to pursue surgery but needs more intensive chronic pain management. I would recommend consultation with the pain management group here in town who are better equipped to follow long-term pain medication use. However, my thought is that he may not get a whole lot of benefit from chronic opioid use, and given the side effects and marginal efficacy of these in chronic low back pain, I would recommend avoiding them if possible.

I do appreciate this referral. If there are any questions regarding Mr. Bliss's visit, please feel free to contact me.



Adam T. Kafka, M.D.

DD: 07/26/2011

DT: 07/27/2011 8:42 A kp

Date 7/27/11 Time 8

cc: Charles L. Kreshel, M.D.

Keith Lohdja, M.D., 8005 Farnam Drive, Suite 305, Omaha, NE 68114

MADONNA REHABILITATION HOSPITAL
OUTPATIENT CLINIC NOTE

193245 Page 4
Original

NAME: Bliss, David R
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PHYSICIAN: Adam T. Kafka, M.D.

MRH00009

09/26/2011 09:57:43 AM

Remote ID ->

Page 18 / 29



Thygesen

Physical Therapy

7/30/2011

Keith R. Lodhia, M.D.
Midwest Neurosurgery & Spine Specialists
8005 Farnham Drive, Suite 305
Omaha, NE 68114

Dr. Lodhia

RE: David Bliss

Mr. David Bliss presented to my clinic on 6/30/2011 for Functional Capacity Evaluation testing. A standard 1 day Core FCE was performed which involved a detailed musculoskeletal assessment followed by performance of standardized objective testing to determine his current physical abilities and safe lifting maximum recommendations. No specific job description was provided by the employer therefore determining a definitive job match was not fully possible. The only information that was communicated to me by his case worker (Eileen Warner) regarding physical job demand information was that the physical demand level of his job is categorized as HEAVY.

Therefore, given this information I have compared his performance on the FCE to physical demand characteristics of HEAVY as classified in the Dictionary of Occupational Titles (DOT). Please refer to the specifics of his performance on the FCE GRID for further details.

If you would have any further need to obtain information pertaining to specific tasks or physical demands testing pertaining to his job I would be more than happy to retest any items you would request. If you have any questions regarding any information on the FCE report please contact me directly at 402-423-7878.

Thank you again for this FCE referral



Paul Thygesen PT

MADONNA REHABILITATION HOSPITAL

OUTPATIENT CLINIC NOTE ON: Bliss, David R

DATE OF SERVICE: 08/25/2011

TIME IN: 10:15 TIME OUT: 10:45

Greater than 25 minutes were spent today with Mr. Bliss, the majority of which was in case discussion and management as well as patient education.

INTERIM HISTORY: David returns today for followup regarding his low back pain. The initial visit I had with Mr. Bliss was on 07/26/11 upon referral from Dr. Keith Lohdia in Omaha. Briefly, he has a history of low back pain with several injuries that stem back to 2003, at which point he underwent laminectomy. He has subsequently had microdiscectomy and revision 3 times over the past year and a half or so. These were all done by Dr. Noble, but Dr. Lohdia was discussing possible lumbar fusion as a more definitive treatment. He came to me for any further rehabilitation recommendations that would be nonsurgical in nature. I did not feel that there was much indication for therapeutic injections given the diffuse nature of his axial pain that seemed primarily mechanical in nature. He does have some radicular symptoms with EMG evidence of mild chronic inactive right L5 radiculopathy.

I had recommended David continue with physical therapy and try a neuropathic pain agent. I wrote for Lyrica 50 mg t.i.d., and he is taking it about twice a day. It does help reasonably well with pain control, but it also makes him tired. He still takes tramadol as needed. There has not been a whole lot of change in his symptoms. He continues to work with physical therapy 2 days per week at the Center for Spine & Sport Rehab. It sounds like they are mainly doing some e-stim type activities using the ReBuilder system. He is looking to get this at home.

Most of our discussion today was David expressing his concerns and frustrations over this entire process. He feels as though his pain is significant enough that it is not allowing him to do any sort of physically demanding job. Even chores around the house cause quite a bit of pain. He also had a day at work when he spent most of the day in meetings in a chair and then the next day was having a flare-up of his pain, so sedentary activity also bothers him quite a bit. He has not returned to see Dr. Lohdia since his last visit but does have a scheduled appointment. It is still unclear whether or not he will pursue any further surgical interventions.

PHYSICAL EXAMINATION: On brief exam, David is well appearing and in no distress. He does not visibly appear to be in significant pain, and he walks with a symmetric and nonantalgic gait. No evidence of footdrop is present. Further examination was deferred in favor of case discussion.

IMPRESSION: David Bliss is a 56-year-old gentleman with chronic mechanical low back pain and mild right L5 radiculopathy. This was demonstrated electrodiagnostically, although the pain seems to be primarily on the left leg which was normal.

MADONNA REHABILITATION HOSPITAL
OUTPATIENT CLINIC NOTE

NAME: Bliss, David R
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PHYSICIAN: Adam T. Kafka, M.D.

196010 Page 1
Original

MRH00004

RECOMMENDATIONS: At this point I do not have a whole lot of further recommendations from a rehabilitation standpoint. If he is to pursue surgery, this will have to be decided between he and Dr. Lohdia, and with presumed segmental instability due to his prior surgeries, he may in fact get good benefit from this. I would obviously have to defer that decision to he and his surgeon.

From a medication standpoint, I would not use any stronger opioids than his tramadol. This is chronic in nature, and given his sensitivity to medications causing him sedation, I would try and escalate the Lyrica as tolerated and otherwise stick to antiinflammatories and other nonnarcotic pain medications.

I would continue with physical therapy. If the ReBuilder system is helping him with symptom relief, I would recommend it. I think it is reasonable to advance to more functional conditioning and work hardening, especially if there is no further surgery planned. This way we could get him at least as functional as possible, even if he does have ongoing pain.

I did not schedule any formal followup. At some point, he will likely be at maximum medical improvement, assuming no surgery is performed. I would have to defer to either Dr. Lohdia or Dr. Noble as to when that point would be. Based on his recent history, he may in fact have already reached that point. Furthermore, since there has been an FCE performed, if this is everyone's opinion, then I would recommend using information from the FCE as well as his physical examination to recommend future work restrictions. I did not address any work restrictions today with Mr. Bliss.

am

Adam T. Kafka, M.D.

DD: 08/25/2011

DT: 08/30/2011 4:00 P kp

Date 8/11/11 Time 2

cc: Keith Lohdia, M.D., 8005 Farnam Drive, Suite 305, Omaha, NE 68114
Workers' Compensation

MADONNA REHABILITATION HOSPITAL
OUTPATIENT CLINIC NOTE

NAME: Bliss, David R
SERVICE DATE: 08/25/2011
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MEDICAL RECORD NUMBER: 13-30-81
PHYSICIAN: Adam T. Kafka, M.D.

196010 Page 2
Original

MRH00005

09/26/2011 09:57:43 AM

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Page 6 / 29



8005 Farnam Drive, Suite 305
Omaha, Nebraska 68114
ph: (402) 398-9243
fax (402) 398-9253

Account #: 104758
Requesting MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1955

09/02/2011

Dear Charles Kreshel:

David Bliss was seen today in consultation for forty-two minutes. I reviewed David's studies and discussed results with him. I reviewed his old notes and reviewed Dr. Kafka's notes for physiatry. I looked over his physical therapy notes as well as functional capacity evaluation. He was listed in a physical functional capacity as having no limitations on heavy demand, although he had a lot of pain that developed right after this and has limited him significantly. He has noted more S1 radicular symptoms with numbness and some pain and particularly pain in the back with twisting or movements. If he sleeps he only gets a couple of hours of sleep and then wakes up and has to reposition because of the pain. Any kind of working in awkward positions bothers him as well. He takes Lyrica and Tramadol all the time. This is much more on the left side than the right side and follows an S1 distribution. He was found on EMG to have a chronic and active mild L5 radiculopathy likely related to his previous 3 surgeries.

His MRI showed laminectomy changes at the hemilaminotomy on the right L5-S1, bilateral laminectomy changes L4-5 and left sided L3 hemilaminectomy changes. He has degenerative disc at 3 levels as well as significant facet disease at those 3 levels. The other levels look fairly good in their condition. He has posterior spondylolisthesis Grade I at L3-4.

David's exam is unchanged with the exception of depressed reflexes and S1 radicular symptoms even a little numbness as he was sitting here. He has several well healed dorsal midline incisions and otherwise is not tender in the back. He transitions from sitting to standing with shocks of pain and walks with some mild antalgia.

- 1) Lumbar spondylolisthesis.
- 2) Lumbar spondylosis.
- 3) Lumbar disc degeneration.
- 4) Lumbar radiculitis.

Recommendations: David and I had a long discussion about his condition. He certainly can't function at his job with his current pain level and would need to be in a light duty situation. He has spondylolisthesis and spondylosis with facet degeneration as well as disc degeneration. I think most of his symptoms probably are facet mediated and may be even causing some of his radicular light complaints.

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09/26/2011 09:57:43 AM

Remote ID ->

Page 7 / 29

Page 2 - David R. Bliss

I would like for him to try some facet blocks both as a diagnostic and possible therapeutic effect and if this seems to help, maybe a facet rhizolysis might be an option as opposed to a fusion at 3 levels. However I would recommend the posterolateral and interbody fusion at L3 to S1 if he continues to have refractory severe pain. His lifestyle is extremely limited in what he can even do when he's not working. David's questions were answered to his satisfaction and he's in agreement with our plan.

Sincerely,

A handwritten signature in black ink, appearing to read 'Keith R. Lodhia', with a stylized flourish at the end.

Keith R. Lodhia, MD

Dictated but not proofread

MNASS00007



8006 Farnam Drive, Suite 306
Omaha, Nebraska 68114
ph: (402) 398-9243
fax (402) 398-9263

Account #: 104758
Requesting MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
08/21/1955

11/07/2011

Dear Dr. Kreshel:

David Bliss is here in the neurosurgery clinic in followup. David was seen for 25 minutes in consultation, half of which was in counseling. We discussed findings on his MRI with him and his wife. He had rhizolysis by Dr. Devney and actually had excellent response to this with near complete resolution of his lumbar back pain, only a little lower sacroiliac region discomfort at times and some occasional upper thoracic, mid-thoracic pain. He still has burning in the back of his heels and on the lateral foot if he walks for 20 minutes or more unless he takes Tramadol or hydrocodone. He gets some "aching" in his anterior hips and at the belt line and a little bit into his knees on occasion. He is worried because he doesn't think he can go back to work. He had a functional capacity evaluation on 07/30/11. He still has difficulty with walking. He can't walk more than 20 minutes which is bothering him the most. He feels like he's not very independent because of this. He would like to seek treatment for this.

I told him for chronic nerve issues I don't really have a good solution surgically with the exception of some possible spinal cord stimulator. He does have chronic mild L5 radiculopathy on the right although the left was normal. His symptoms seem to be more S1 mediated. I do think he would be a possible candidate for spinal cord stimulator and we will get him set up for an evaluation and possible trialing of the spinal cord stimulator. I did tell him that the fusion would not make him any better with regards to his lumbar spine as this seems to have already been improved significantly with his rhizotomy.

He will likely need to continue on medications at least in some form as needed indefinitely unless he gets some relief with the spinal cord stimulator.

Sincerely,

Keith R. Lodhia, MD

Dictated but not proofread

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09/26/2011 09:57:43 AM

Remote ID ->

Page 18 / 29



Thygesen

Physical Therapy

EXHIBIT NO. <u>60</u>
OCT 16 2012
LISA GRIMMINGER, RMR, CRR

7/30/2011

Keith R. Lodhia, M.D.
Midwest Neurosurgery & Spine Specialists
8005 Farnham Drive, Suite 305
Omaha, NE 68114

Dr. Lodhia

RE: David Bliss

Mr. David Bliss presented to my clinic on 6/30/2011 for Functional Capacity Evaluation testing. A standard 1 day Core FCE was performed which involved a detailed musculoskeletal assessment followed by performance of standardized objective testing to determine his current physical abilities and safe lifting maximum recommendations. No specific job description was provided by the employer therefore determining a definitive job match was not fully possible. The only information that was communicated to me by his case worker (Eileen Warner) regarding physical job demand information was that the physical demand level of his job is categorized as HEAVY.

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Thank you again for this FCE referral



Paul Thygesen PT

09/26/2011 09:57:43 AM

Remote ID ->

Page 19 / 29

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen
Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510



WorkWell FCE History

Name: David Bliss
Dates of FCE Testing: 06/30/2011
Date of Birth: 06/21/1955
Date of Injury: 02/04/2011
Gender: M
Address: 1801 Preamble Ln.
City/State/Zip: Lincoln, Nebraska 68521
Primary Diagnosis: 722.73
Area of Injury: Low Back
Occupation: Railroad Carman
Dept of Labor Category of Work:
Heavy

Mechanism/Type of Injury:
Lifting injury of heavy/awkward piece of equipment.

Previous Treatment:
Conservative physical therapy, pain physician evaluation and treatment, lumbar surgery x 3,

Pertinent Surgery/Other Clinical Tests/Past Medical History:
Lumbar Surgery x 3, Knee surgeries, left RTC.

Current Medications:
Tylenol

Functional Status/ Activity Level:
Client indicates he is able to perform majority of day to day tasks independently "depending on how his back feels" Client indicates independence with ADL's. Client indicates intermittent disruption in sleep pattern due to back pain.

Chief Complaints/Symptoms:
Client reports that he has residual left LE weakness following injury and surgeries and continues to experience variable intermittent back pain but tolerates this and "gets on with his life".

Return to Work Information:
not working

Goals:
Client wishes to remain employed and return to work.

Signature

Paul Thygesen PT

Date

7-30-11

09/26/2011 09:57:43 AM

Remote ID ->

Page 20 / 29

Client Name: David Bliss
 FCE Dates: 06/30/2011
 Therapist: Paul Thygesen
 Thygesen Physical Therapy
 5955 S 56th St Ste 1
 Lincoln, NE 68510



WorkWell FCE Physical Exam

Systems Review

Blood Pressure: 140/90
 Height: 65"
 Heart Rate (resting): 69
 Weight: 220

Gait: WFL's

Posture: Client demonstrates sway back type posture with hips mildly shifted to the left and left shoulder girdle elevated.

Coordination: Client demonstrated functional coordinatoion with no observable deficits.

Movement Characteristics(speed, smoothness, posturing): Client demonstrated functional gait and movement between sitting, standing, and supine position changes with no specific deficit areas.

Atrophy/Edema: None observed in lumbar region

Integumentary: WNL's, well healed midline lumbar incisions observed.

Muscle Tone Spasms: Client demonstrated moderate increase in muscle tone through the bilateral lumbar and lower thoracic paraspinals and additionally at the left superior shoulder involving the muscles of shoulder girdle (scapular) elevation.

PAR-Q

Yes	No	Question
	X	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
	X	2. Do you feel pain in your chest when you do physical activity?
	X	3. In the past month, have you had chest pain when you weren't doing physical activity?
	X	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
X		5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
	X	6. Is your doctor currently prescribing drugs (for example, water pills) for blood pressure or heart condition?
	X	7. Do you know any other reason why you should not do physical activity?

Musculoskeletal System

Neck	Normal	Range of Motion	Muscle Strength
Flexion	45	WNL	5
Extension	45	WNL	5
Right Lateral Flexion	45	WNL	5
Left Lateral Flexion	45	WNL	5
Right Rotation	90	WNL	5
Left Rotation	90	WNL	5

Trunk	Normal	Range of Motion	Muscle Strength
Flexion	80	55-60	4+/5
Extension	30	20-25	5
Right Lateral Flexion	35	25-30	4+/5
Left Lateral Flexion	35	25-30	4+/5

Page 1 of 5

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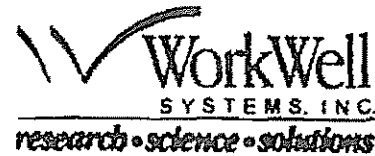
Remote ID ->

Page 21 / 29

Client Name: David Bliss

FCE Dates: 06/30/2011

Therapist: Paul Thygesen

Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510

Trunk	Normal	Range of Motion	Muscle Strength
Right Rotation	45	40-45	4+/5
Left Rotation	45	35	4+/5

Comments/Quality of Motion - Spine

Client demonstrates AROM decrease in planes of flexion, extension, right and left lateral flexion and rotation. Client demonstrates mild strength decrease in planes of flexion, right and left side flexion and rotation. Client c/o pain and stiffness at the limits of lower trunk extension and left rotation.

		Range of Motion		Muscle Strength	
Shoulder	Normal	Right	Left	Right	Left
Forward Flexion	180	WNL	WNL	5	5
Extension	60	WNL	WNL	5	5
Abduction	180	WNL	WNL	5	5
Internal Rotation	70	WNL	WNL	5	5
External Rotation	90	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Elbow	Normal	Right	Left	Right	Left
Flexion	150	WNL	WNL	5	5
Extension	0	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Forearm	Normal	Right	Left	Right	Left
Pronation	80	WNL	WNL	5	5
Supination	80	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Wrist	Normal	Right	Left	Right	Left
Flexion	80	WNL	WNL	5	5
Extension	70	WNL	WNL	5	5
Ulnar Deviation	30	WNL	WNL	5	5
Radial Deviation	20	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Gross Hand Motion	Normal	Right	Left	Right	Left
Composite Motion		WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Hip	Normal	Right	Left	Right	Left
Flexion (knee extd)	90	WNL	WNL	5	4+/5
Flexion (knee fld)	120	110-115	110-115	4+/5	4+/5
Abduction	45	WNL	WNL	4+/5	4+/5
Adduction	30	WNL	WNL	4+/5	4/5

Page 2 of 5

MNASS00021

09/26/2011 09:57:43 AM

Remote ID ->

Page 22 / 29

Client Name: David Bliss

FCE Dates: 06/30/2011

Therapist: Paul Thygesen

Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510

		Range of Motion		Muscle Strength	
Hip	Normal	Right	Left	Right	Left
Extension	30	WNL	WNL	5	4+/5
Internal Rotation	45	WNL	WNL	5	5
External Rotation	45	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Knee	Normal	Right	Left	Right	Left
Flexion	135	WNL	WNL	5	4 - 4+/5
Extension	0	WNL	WNL	5	4 - 4+/5

		Range of Motion		Muscle Strength	
Ankle	Normal	Right	Left	Right	Left
Plantar Flexion	50	WNL	WNL	5	5
Dorsiflexion	20	WNL	WNL	5	4+/5
Inversion	35	WNL	WNL	5	5
Eversion	15	WNL	WNL	5	5

Other

Toe Rise Reps	Right	10	Left	10
Knee Squat	20			

Comments/Quality of Motion - Lower Quarter

Client demonstrated decreased hip ROM in planes of flexion bilaterally. Client demonstrated hip weakness in planes of flexion, extension, abduction, adduction. Client demonstrates muscle weakness to manual muscle testing with bilateral hip flexion, abduction/adduction, left hip extension. Client demonstrates muscle weakness of the left quadriceps and hamstrings. Client demonstrates left dorsiflexion weakness.

Neuromuscular System

Sensory Testing	Client reports chronic decreased sensation of left anteromedial leg (reported from medial malleolar region to medial knee/thigh).
Reflex Ankle Jerk	Absent left ankle jerk reflex
Reflex Knee Jerk	Absent left patellar reflex
Reflex Upper Extremities	WNL's

Screening for Gross Balance

Attribute	Trial 1(Times)	Trial 2(Times)
Standing on Floor, Eyes Open	30	30
Standing on Floor, Eyes Closed	30	30
Standing on Foam, Eyes Open	30	30
Standing on Foam, Eyes Closed	30	30

First Day Summary of Physical Assessment

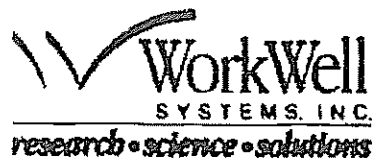
Client demonstrated muscle tone increase in bilateral thoracolumbar paraspinal muscles, left shoulder girdle/scapular elevators. Client demonstrates postural asymmetries. Client demonstrates decrease in AROM of trunk flexion, extension, lateral flexion and

09/26/2011 09:57:43 AM

Remote ID ->

Page 23 / 29

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen
Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510



rotation. Client demonstrates mild strength deficit in planes of flexion, right and left side flexion and rotation. Client c/o stiffness/pain at limits of lower trunk extension and left rotation. Client demonstrates decrease in hip ROM in the planes of flexion bilaterally and muscle weakness in planes of flexion, extension, abduction and adduction. Client demonstrates left quadriceps and hamstrings weakness and left dorsiflexion weakness. Please refer to the physical exam grid for specific tested ROM and strength values.

Signature

Date

Paul J. Thygesen
7-30-11

09/26/2011 09:57:43 AM

Remote ID ->

Page 24 / 29

Client Name: David Bliss
 FCE Dates: 06/30/2011
 Therapist: Paul Thygesen
 Thygesen Physical Therapy
 5955 S 56th St Ste 1
 Lincoln, NE 68510



WorkWell FCE Test Results and Interpretation

The interpretation of WorkWell's standardized functional testing is based on assumptions including normal breaks, basic ergonomic conditions and that the tested functions are not required more than 2/3 of a normal working day. If a function is required continuously, job specific testing should be performed.

Client Name: David Bliss
 Test Date: 06/30/2011

Interpretation of observed function regarding activity during a normal working day

Frequency	Weighted Activities Observed Effort Level	Position/Ambulation Quantitative + Qualitative Results	% of Workday
NEVER	Contraindicated	Not Possible	0%
RARELY	Maximum	Significant Limitation	1-5%
OCCASIONALLY	Heavy	Some Limitation	6-33%
FREQUENTLY	Low	Slight/No Limitation	34-66%
SELF LIMITED	Client stopped test; submaximum effort level		Submax percent

Lifting, Strength (lbs)	Never	Max Rare 1-5%	Heavy Occ 6-33%	Low Freq 34-66%	Limitations	Recommendations
Waist to Floor (11 in. from floor)		65	65	30		
Waist To Crown (Handles)		50	40	20		
Front Carry		65	50	35		

Posture, Flexibility, Ambulation	Never	Significant Limitation Rare 1-5%	Some Limitation Occ 6-33%	Slight/No Limitation Noted Freq 34-66%	Limitations	Recommendations
Elevated Work (Weighted - 2# cuff on both wrists)				X		
Forward Bending-Standing				X		
Standing Work				X		
Crouch				X		
Kneel - Half Kneel				X		
Stairs				X		
Walk - 6 Min Walk Test				X		
Sitting				X		

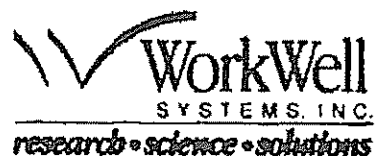
Push-Pull (Static)	Force Generated (pounds)	Limitations	Recommendations
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09/26/2011 09:57:43 AM

Remote ID ->

Page 25 / 29

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen
Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510



Push-Pull (Static)	Force Generated (pounds)	Limitations	Recommendations
Push Static	75		
Pull Static	83		

(Numerous variables impact Push/Pull force including load, equipment, surface, etc. These forces do not represent the amount of weight that is moved.)

Signature

Date

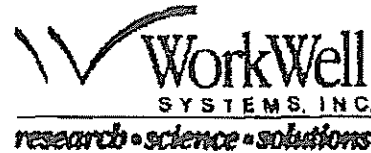
Paul Thygesen PT
7-20-11

09/26/2011 09:57:43 AM

Remote ID ->

Page 26 / 29

Client Name: David Bliss
 FCE Dates: 06/30/2011
 Therapist: Paul Thygesen
 Thygesen Physical Therapy
 5955 S 58th St Ste 1
 Lincoln, NE 68510



WorkWell Functional Capacity Evaluation

Summary Report

Name: David Bliss
 Test Date: 06/30/2011
 Date of Birth: 06/21/1955
 Gender: M
 Address: 1801 Preamble Ln.
 City: Lincoln
 State: Nebraska
 Zip Code: 68521
 Phone: 402-525-6110
 Physician: Dr. Keith R. Lodhia
 Employer: BNSF Railroad
 Primary Diagnosis: 722.73

Reason for Testing

Determine ability to return to previous job or other job.
 Evaluation to determine functional abilities and limitations

Description of Test Done

One day Core WorkWell FCE

Cooperation and Effort

Client demonstrated cooperative behavior and was willing to work to maximum abilities in all test items

Consistency of Performance

Client gave maximal effort on all test items as evidenced by predictable patterns of movement including increased accessory muscle recruitment, counterbalancing and use of momentum, and physiological responses such as increased heart rate.

Pain Report

Client reported discomfort present in lumbar region and hamstrings toward the end of testing during static standing in forward trunk flexed position, but there was no interference in safety.

Safety

Client demonstrated safe performance using appropriate body mechanics throughout all subtests.

Quality of Movement

Client demonstrated safe and appropriate changes in body mechanics, including use of accessory muscles, counterbalancing and momentum, as load/force increased. These changes are expected and consistent with maximal effort.

Abilities/Strengths

Client demonstrated significant abilities in grip strength, hand coordination, lifting, and carrying. Please refer to the FCE GRID for specific information.

Limitations

Client demonstrated no specific physical limitations pertaining to the test items performed on this Core FCE.

Physical Return to Work Options Explored

The client's safe lifting maximums meet the PDL level HEAVY category. Please refer to the Job Match Grid for details.

Therapist's Recommendation Regarding Return to Work

Unable to obtain job description

US Department of Labor Physical Demand Level

Heavy

Signature

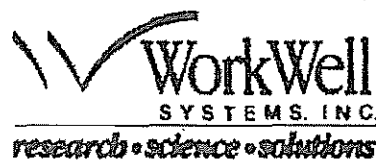
Page 1 of 9

09/26/2011 09:57:43 AM

Remote ID ->

Page 27 / 29

Client Name: David Bliss
FOE Dates: 06/30/2011
Therapist: Paul Thygesen
Thygesen Physical Therapy
5955 S 58th St Ste 1
Lincoln, NE 68510



Date 7-30-11

CD

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

DAVID BLISS,)
)
Plaintiff,) CASE NO. 4:12CV3019
)
vs.) DEPOSITION TAKEN IN
)
BNSF RAILWAY COMPANY,) BEHALF OF DEFENDANT
)
Defendant.)

DEPOSITION OF: DR. LIANE E. DONOVAN
DATE: October 4, 2012
TIME: 1:05 p.m.
PLACE: 6940 Van Dorn Street, Suite 201,
Lincoln, Nebraska

APPEARANCES:

Mr. William J. McMahon
Attorney at Law
542 South Dearborn Street
Suite 200
Chicago, IL 60605 for Plaintiff
Mr. James B. Luers
Attorney at Law
1248 O Street
Suite 800
Lincoln, NE 68508 for Defendant

Job No. CS1336570

I-N-D-E-X

WITNESS	Direct	Cross	Redirect	Recross
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DR. L. DONOVAN	3	46	61	--
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EXHIBITS

Marked Offered

51. Spine & Pain Centers Medical

Records	12	--
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52. Supplemental Doctor's

Statement	47	--
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53. NPC Follow-Up Clinical

Visit Forms	67	--
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1 S-T-I-P-U-L-A-T-I-O-N-S

2 It is hereby stipulated and agreed by and
3 between the parties that;

4 Notice of taking said deposition is
5 waived; notice of delivery of said deposition
6 is waived.

7 Presence of the witness during the
8 transcription of the stenotype notes is waived.

9 All objections are reserved until the time
10 of trial except as to form and foundation of
11 the question.

12 DR. LIANE E. DONOVAN,
13 Of lawful age, being first duly cautioned and
14 solemnly sworn as hereinafter certified, was
15 examined and testified as follows:

16 DIRECT EXAMINATION

17 BY MR. LUERS:

18 Q. Good afternoon, Doctor. My name's Jim
19 Luers.

20 Would you state your full name and spell
21 your last name, please.

22 A. Liane Donovan, D-O-N-O-V-A-N.

23 Q. And your office address?

24 A. 6940 Van Dorn, Suite 201.

25 Q. Doctor, you are a physician; is that

1 correct?

2 A. Correct.

3 Q. Practicing here in Lincoln, Nebraska?

4 A. Correct.

5 Q. And what is your specialty?

6 A. Pain medicine.

7 Q. Are you board certified in that
8 specialty?

9 A. Yes.

10 Q. And how long have you been practicing
11 then?

12 A. Since '94.

13 Q. Okay. Is that with the same clinic
14 here, the Pain -- Spine and -- or the Pain
15 and --

16 A. I know. It keeps changing.

17 Q. What is it? Okay.

18 A. Yes. But that's -- this officially
19 began I think in 2003.

20 Q. What's the name of it now?

21 A. Spine and Pain Centers of Nebraska.

22 Q. Okay. And you practice with some other
23 specialists?

24 A. Yes.

25 Q. How many?

1 A. I practice with two other specialists.

2 Q. What are their names?

3 A. John Massey and Phil Essay.

4 Q. Okay. Is Dr. Devney then in your
5 clinic?

6 A. No, he is not.

7 Q. Where does he practice?

8 A. Omaha.

9 Q. Okay. All right. So he's not
10 associated with you in any way?

11 A. No.

12 Q. Doctor, have you had your deposition
13 taken before?

14 A. Yes.

15 Q. All right. So you're familiar with the
16 process?

17 A. Yes.

18 Q. Are you acquainted or do you know Mr. --
19 what's his first name?

20 A. David.

21 Q. David Bliss?

22 A. Yes.

23 Q. Yes. As we sit here today, do you have
24 an independent recollection of Mr. Bliss?

25 A. Yes.

1 Q. All right. Can you tell me how you
2 first met him?

3 A. I first met him in an evaluation for
4 spinal cord stimulator.

5 Q. Okay. So he came to your office; is
6 that right?

7 A. Yes.

8 Q. Had you ever done any treatment on
9 Mr. Bliss prior to that?

10 A. No.

11 Q. And had you ever known any other members
12 of his family or treated any other members of
13 his family?

14 A. No.

15 Q. All right.

16 A. Not that I know of.

17 Q. Do you know who recommended you to him?

18 A. I think he came in referral from
19 Dr. Lodhia.

20 Q. And is that -- do you typically get
21 referrals from Dr. Lodhia?

22 A. Yes.

23 Q. For pain patients?

24 A. Yes.

25 Q. All right. Are you acquainted with

1 Mr. Bliss' attorney?

2 A. No.

3 Q. All right. Never spoken with him?

4 A. No.

5 Q. Are you aware, Ma'am, that there is a
6 lawsuit pending in this case involving
7 Mr. Bliss?

8 A. I'm aware now.

9 Q. Okay. You weren't at -- as of recent
10 times?

11 A. No, I was not.

12 Q. Okay. Have you ever, to your knowledge,
13 treated other railroad employees that are
14 involved with pending lawsuits?

15 A. I assume I probably have. But I can't
16 think of anybody.

17 Q. Not familiar?

18 A. Yes.

19 Q. Okay. As we sit here today, are you
20 familiar with specific crafts or job duties of
21 railroad workers?

22 A. No. The only thing that I am aware of
23 in general is that unless they are 100 percent,
24 it's hard to return to work, is how I
25 understood it.

1 Q. Okay. But you know -- but as you sit
2 here today, for example, you don't know what --
3 job requirements of a carman at the --

4 A. No.

5 Q. -- Lincoln shops?

6 A. I do not.

7 Q. Okay. And you are not a voc expert; is
8 that correct?

9 A. Correct.

10 Q. So you don't typically render opinions
11 as to whether an individual can return to work
12 or what types of activities that individual can
13 actually engage in in terms of work?

14 A. No, I do not.

15 Q. And you don't anticipate offering those
16 kinds of opinions in this case, do you?

17 A. No, I do not.

18 Q. How about FCEs? Do you get involved in
19 your practice in conducting functional capacity
20 evaluations?

21 A. Rarely. More often we send them out.

22 Q. All right. Are you familiar with
23 typically how they are run?

24 A. Yes.

25 Q. And when you send them out, do you

1 generally then look at the report and evaluate
2 them yourself?

3 A. Yes.

4 Q. Okay. Have you ever seen one conducted
5 on Mr. Bliss?

6 A. I have.

7 Q. All right. Do you have that one from
8 WorkWell dated --

9 A. Yes.

10 Q. Looks like it's dated --

11 A. 6-30-11.

12 Q. Correct. You were provided with that?

13 A. Yes.

14 Q. Do you remember when or how?

15 A. Just before this deposition.

16 Q. Oh, really?

17 A. Yes.

18 Q. How did that come to you?

19 A. Just came in a form of just past
20 records.

21 Q. Okay. Who provided it to you?

22 A. My work comp nurse.

23 Q. Okay. How did you -- did you make a
24 request for that?

25 A. I, prior to depositions, request prior

1 records.

2 Q. All right. What other records were
3 provided then just prior to this deposition?

4 A. I just -- I have Dr. Lodhia's notes.
5 And I have an EMG study.

6 Q. And could you tell me, please, what date
7 are the noted -- are the notes from Dr. Lodhia?

8 A. He has one -- and this may have been in
9 the record. Although, I'm not sure. This
10 one's from 11-7-11, just a letter to
11 Dr. Kreshel.

12 Q. Okay.

13 A. And then I have another one of his that
14 is from 9-2-11. And that is another letter to
15 Dr. Kreshel.

16 Q. Okay.

17 A. And that's all the notes I have.

18 Q. And then you've got the --

19 A. I have the EMG.

20 Q. And when is that dated?

21 A. That is dated 7-13-11.

22 Q. From -- and who provided that to you?

23 A. Actually, I think I had that prior
24 because I was aware of the EMG.

25 Q. Okay.

1 A. And then I have the functional capacity
2 evaluation from 6-30-11.

3 And then I have an old op report. But I
4 already had this prior from Dr. Noble from
5 2003.

6 Q. Very good. So all of those documents
7 were provided to you -- when you say just
8 prior, is that, like, within the last week?

9 A. Yes.

10 Q. Okay. Prior to that, prior to this past
11 week --

12 A. Yes.

13 Q. -- did you have an opportunity to review
14 old medical history of Mr. Bliss?

15 A. I was aware of his 2003 operation. And
16 I was aware of Dr. Devney's notes regarding a
17 radiofrequency he had done.

18 Q. And Dr. Devney actually got involved
19 with this particular client in looks like
20 September of 2011; is that right?

21 A. Yes.

22 Q. Okay. So other than those -- other than
23 those medical records, you're not aware of any
24 other medical history?

25 A. No, I'm not.

1 Q. All right. With regards to the WorkWell
2 FCE, did you have an opportunity then in the
3 past week to review that?

4 A. Yes, I have.

5 Q. Is there anything in there that jumps
6 out at you that would suggest to you that it's
7 not valid or it wasn't valid at the time it was
8 taken?

9 A. No, I do not.

10 Q. All right. At least as of the date of
11 June 30th, 2011, it appears to be a valid
12 evaluation of his physical -- of Mr. Bliss'
13 physical capabilities?

14 A. Yes.

15 Q. Okay. Dr. Devney saw the patient.

16 MR. LUERS: I'm going to mark
17 this as an exhibit.

18 (Exhibit No. 51 marked for
19 identification.)

20 Q. (BY MR. LUERS) Doctor, I've put together
21 what I hope to be a fairly complete compilation
22 of Dr. Devney and then your office notes. And
23 it's marked as Exhibit 51.

24 It appears that Dr. Devney first saw
25 Mr. Bliss on September 9th of 2011. Is that

1 your understanding?

2 A. Yes.

3 Q. When Dr. Devney sent the patient or --
4 no. Dr. -- I'm sorry. Dr. Devney didn't refer
5 the patient to you. Was it -- well, wait a
6 minute.

7 A. You know, that's --

8 Q. Strike that.

9 A. It's a good question. And I'm trying to
10 remember how he came. I have it written as
11 Dr. Lodhia. But I'm not sure whether it might
12 have come through Devney.

13 Q. I think maybe I did see --

14 A. Did it come through him? It's possible.

15 Q. Well, it doesn't matter. But at any
16 rate, let me -- let me -- when he -- when
17 Mr. Bliss came to you, you had at least been
18 provided with Dr. Devney's medical records;
19 correct?

20 A. Yes.

21 Q. And as of 9-9 of 2011, if you could look
22 at pages -- that initial report of
23 Dr. Devney --

24 A. Uh-huh.

25 Q. -- on the second page, the objective --

1 looks like a -- sort of a general physical
2 exam --

3 A. Yes.

4 Q. -- with the exception of some loss of --
5 slight loss of sensation on the left foot and
6 some reflexes that are absent, would you agree
7 with me, Doctor, that that physical exam was
8 pretty normal?

9 A. Yes.

10 Q. And the impression then included a
11 variety of these low back pain, mostly lumbar
12 disc degeneration, facet and probably lumbar
13 spinal stenosis. Are those -- can all of those
14 be attributed to longstanding spine
15 degeneration?

16 A. Yes.

17 Q. Okay. And is it -- was it your
18 understanding that at least as of that initial
19 report, Dr. Devney didn't impose any
20 restrictions on Mr. Bliss?

21 A. Not that I am aware of.

22 Q. All right. 9-19 was his next report.
23 And that begins on page 5.

24 Again, the condition was generally
25 negative except for a few of the -- of the

1 original complaints; correct?

2 A. Yes.

3 Q. 9-26, they -- he proceeded with a -- is
4 that a rhizotomy?

5 A. Yes.

6 Q. Tell me what that is, Doctor.

7 A. It is a -- it is a alternating current.
8 It's actually a burn of the nerve to the joint,
9 the facet joint in the back. So he --

10 Q. What is the purpose of that?

11 A. It is with the understanding that the
12 pain in the back is related to facet pain or
13 facet-mediated pain so arthritis in the spine
14 and that the intent of the rhizotomy is to
15 remove the sensory portion of what somebody
16 feels with that range of motion in the joint
17 and, therefore, decrease their pain.

18 Q. Is that -- and like you said, that's
19 done on patients that are suffering from, like,
20 multi-level degenerative spine?

21 A. Usually multi-level facet degeneration.

22 Q. Okay.

23 A. So it only works -- you do the medial
24 branch or the diagnostic block to prove that a
25 good portion of their back pain is related to

1 the joint.

2 Q. Okay.

3 A. And not a disc or anything else.

4 Q. So if the pain is alleviated, then it
5 is, at least some of the pain that they're
6 complaining of is related to the facet joint?

7 A. Yes.

8 Q. And is the facet joint something that,
9 again, degenerates over time and that can be a
10 normal process?

11 A. Yes.

12 Q. On November 7th, which is page 12, up
13 above, mark the pages.

14 A. Uh-huh.

15 Q. Under subjective, I think it's the third
16 sentence or fourth sentence, it says, "He
17 reports 95 percent pain reduction."

18 A. Yes.

19 Q. So that's -- that's indicative of, like
20 you said, if it's an arthritis-related
21 condition?

22 A. Yes.

23 Q. And certainly with that kind of pain
24 reduction, there's no indication that as of
25 November 7th of 2011, there would be any reason

1 to impose additional -- or any restrictions;
2 correct?

3 A. Correct.

4 Q. And as far as you know, there were no
5 restrictions?

6 A. As far as I know.

7 Q. Okay. Under the objective portion on
8 that page, 12 --

9 A. Uh-huh.

10 Q. -- it says, toward the bottom, "Lumbar
11 range of motion is full in all directions with
12 mild discomfort. His neurological assessment
13 remains unchanged. No edema noted in the lower
14 extremities." Pretty normal; correct?

15 A. Yes.

16 Q. All right. If we go to November 18th,
17 which is page 14, this is the first time that
18 you actually saw the patient; is that accurate?

19 A. That is correct.

20 Q. Okay. Talk to me a little bit about
21 under the past, family, social, employment
22 history. There is a line there that says,
23 "Work history" --

24 A. Yes.

25 Q. -- "no changes required. He works at

1 BNSF as a carman." Obviously he would have
2 told you -- he would have provided you that
3 information?

4 A. Yes.

5 Q. When you -- says no changes required, I
6 take it at that point in time, you're not
7 imposing any restrictions or limitations?

8 A. It would -- when it says no changes
9 required, it's been updated. That is how he
10 described his work history. So it doesn't
11 necessarily talk about restrictions.

12 It's how they say, like, I'm a
13 secretary. Patient is a secretary. So it
14 doesn't say currently disabled, currently -- I
15 mean, they usually add that if I -- if I -- a
16 change is required, they say currently disabled
17 is a change, then you would remove the -- it
18 would change that way so --

19 Q. Okay. So you would add -- if -- if for
20 some reason either you believed it or the
21 patient believed that he was unable to return
22 to work as a carman, you would add disabled
23 or --

24 A. Correct.

25 Q. -- restricted or --

1 A. Yeah.

2 MR. McMAHON: Objection.

3 Foundation as to what Mr. Bliss thinks.

4 Q. (BY MR. LUERS) But that information
5 would be provided to you then, and that might
6 dictate a change?

7 A. Yes.

8 Q. Okay. In this instance, at least as of
9 November 18th, it was still your understanding
10 that he was working as a carman or would return
11 to work as a carman?

12 A. Yes. I do have in his intake -- and I
13 don't -- this is in his writing. He does say
14 as last date of employment, February 3rd, 2011.

15 Q. Correct.

16 A. But --

17 Q. That's when his alleged injury occurred;
18 correct?

19 A. Yes.

20 Q. At least that's your understanding?

21 A. Yes.

22 Q. Okay. And I think that's in your
23 initial pain overview --

24 A. Yes.

25 Q. -- paragraph of your report.

1 Was there any indication in your initial
2 visit here of November 18th, 2011, that
3 Mr. Bliss was having shoulder problems or
4 complaints of pain in his shoulders?

5 A. No.

6 Q. Go to 12-21, which I think is the next
7 visit that you had with Mr. Bliss. That's on
8 page 18?

9 A. Yes.

10 Q. Was that your next visit?

11 A. Yes.

12 Q. All right. Again, there's no reference
13 to any change in work history there; correct?

14 A. Correct.

15 Q. Is there any indication in that report
16 of any complaints of shoulder pain or shoulder
17 problem?

18 A. On that date -- December 21st?

19 Q. Yes.

20 A. He doesn't say it in his intake with the
21 nurse.

22 But on his picture, his pain diagram, he
23 does draw just a mark across the shoulder
24 there.

25 Q. Okay.

1 A. So at that point -- but he didn't --
2 usually what we discuss or address are the
3 things they want to talk about. So a lot of
4 times with the type of pain patients, we'll
5 often see a whole body covered, but you have to
6 focus on an area. So sometimes when other
7 places are marked, it doesn't necessarily mean
8 we address it unless a patient wishes to
9 address it.

10 Q. Okay. Were you aware at that time that
11 he was treating with any other physicians for
12 shoulder problems?

13 A. No, I was not.

14 Q. He never brought that to your attention?

15 A. No.

16 Q. Were you aware that he had had surgery
17 on December 5th for his shoulder?

18 A. No.

19 Q. Okay. Would -- did he make any -- give
20 you any indication as of December 21st that he
21 had gone through physical therapy at least four
22 times or three times -- three or four times as
23 of that date for the shoulder?

24 A. No, I don't have that.

25 Q. Okay.

1 A. I do see, though, that I have written
2 multiple times that he is in litigation. I
3 guess I just -- that doesn't tend to be
4 something I focused on. So when you asked if I
5 was aware he was in litigation, I must have
6 known it.

7 Q. Oh, no. That's okay.

8 A. Yeah, but I never concentrate --

9 Q. That's fine. You didn't know he was
10 treating for shoulder problems and had surgery
11 and physical therapy?

12 A. I was not aware.

13 Q. Okay. As of that 12-21 visit, at least
14 according to your history, it looks like his
15 pain has improved?

16 A. Yes.

17 Q. And if you look on page 19, down on
18 comments --

19 A. Yes.

20 Q. -- you say, "He's -- he's doing
21 considerably better and pain is something he
22 can live with."

23 And then you go on to say, "He is able
24 to work but not likely at full capacity that he
25 had been."

1 What changed -- what, if anything, if
2 you recall, made you make that comment? First,
3 let me ask you that.

4 A. Usually when -- that wouldn't
5 necessarily -- the comments wouldn't
6 necessarily be based upon a physical exam
7 finding or a change that way. It's usually
8 based upon their statement that they have some
9 concern about whether they would be able to
10 continue to work.

11 Q. Okay. So is it probable that that
12 statement there is based upon what he told you?

13 A. Yes.

14 Q. And then what about, "He would likely be
15 qualified for light or sedentary duty"? Is the
16 same thing true there? Is that what he's
17 telling you?

18 A. I don't recall. Sometimes -- sometimes
19 when they -- they're unsure whether they would
20 be able to work, we would still say -- my job,
21 kind of my opinion of my job is to keep people
22 going, to have them continue to work in some
23 capacity.

24 When someone has chronic pain, the worst
25 thing you can do is to disable them and let

1 them sit at home and not do anything.

2 So most of the time if they can't
3 perform full capacity, such as with a railroad
4 job, is my understanding, light duty or some
5 sort of work to continue to work in some
6 capacity tends to be in a pain patient's best
7 interest and something that we'd recommend or
8 we'd like them to continue.

9 Q. Okay. You weren't -- you weren't
10 rendering an opinion there in that sentence
11 based upon, like, the Social Security work
12 categories as to whether he was eligible for
13 light, medium --

14 A. No.

15 Q. -- or heavy duty?

16 A. No, no. It's not based on specific
17 pounds that he can lift or time that -- no.
18 It's more we believe he should be able to
19 continue to work in some capacity.

20 Q. Okay. Whether it be light or medium?

21 A. Exactly.

22 Q. Okay. And you didn't at that time
23 impose any restrictions on him?

24 A. No.

25 Q. All right. Next visit was March 20th;

1 is that correct?

2 A. I believe so.

3 Q. If you look on the -- page 22, under
4 history, second paragraph, you say -- he says
5 that, "Pain is exacerbated by walking long
6 distance." Can -- do you recall, perchance,
7 what he referenced as being long distance?

8 A. No, I don't recall.

9 Q. Would -- okay. You also say that he
10 gets 80, 90 percent of relief from meds and
11 that the pain is considerably better; correct?

12 A. Correct.

13 Q. Again, when you're doing your physical
14 exam, you note, "No acute distress." So he's
15 doing pretty well at that point?

16 A. Yes.

17 Q. Okay. Go to April 19th, which is the
18 next visit. Same thing, physical exam is
19 pretty much unchanged, relatively good;
20 correct?

21 A. Yes.

22 Q. Exercise program, I think you're
23 recommending under musculoskeletal on the
24 second -- on page 26 --

25 A. Yes.

1 Q. -- you say, "Can undergo exercise
2 testing and/or participate in exercise
3 program." What did you have in mind there,
4 Doctor?

5 A. That's an interesting thing because the
6 electronic medical record, if you -- when
7 you're going through the record, if you push
8 the normal button, it will put that out. I'm
9 not sure that's always an accurate statement.
10 But if you look back probably through the
11 record, it says that each time.

12 It's the assumption that -- I will
13 change it if -- the best thing -- the more
14 accurate thing would be normal gait and
15 station, you know, whatever, no -- that sort of
16 thing rather than what comes out on that form.
17 But that's what it implies.

18 So I would say that he would be able to
19 undergo normal exercise and activity, but that
20 is not a new finding. That's probably how he's
21 been the whole way through.

22 Q. Okay. And then what would -- what would
23 normal exercise and activity be? I mean, in
24 his case, as of April --

25 A. ADLs, whatever he normally does, his

1 activities of daily living. I didn't get the
2 feeling that he was limited in his ability to
3 do the things that he had been doing all along.

4 Q. Okay. And, again, he didn't indicate to
5 you at that time anything changed with regards
6 to his belief that he could -- that he was
7 working as a BNSF carman or could work?

8 A. Yes, he did not.

9 Q. May 21st, 2012, which is the next visit,
10 second paragraph under history -- and, quite
11 frankly, on there you have the referral as
12 Dr. Lodhia.

13 A. It is there?

14 Q. Yeah.

15 A. Okay.

16 Q. It's on page 28.

17 A. Uh-huh.

18 Q. Second paragraph under history.

19 A. Yes.

20 Q. He talks about, "Pain as stiff and sore
21 first thing in the morning and by noon is
22 feeling great. By evening the pain is starting
23 to return." Is that uncommon in this kinds
24 of -- in this kind of condition?

25 A. No, it is not.

1 Q. Okay. What -- what is the precipitating
2 factor for someone that starts getting more
3 pain as the day progresses?

4 A. When we ask about time of day that you
5 have pain, just as a general rule, people who
6 have pain in the morning tend to be more
7 arthritis related, get up in the morning,
8 they're stiff from lying in bed. And so that
9 would be kind of -- when you're looking at
10 facets or when you're looking at that sort of
11 thing, you always kind of look toward morning
12 pain.

13 Pain as the day progresses or more pain
14 towards the end of the day suggests more disc
15 mediated or other causes for pain.

16 So this would suggest he has some return
17 of the arthritis pain but he may also have
18 his -- the pain related to his spine and what
19 he's had in the past.

20 Q. Okay. All right. It says, "Pain is
21 exacerbated by no meds." I guess what? Did he
22 take himself off the meds? Is that what he's
23 saying?

24 A. I think he's saying when he's not taking
25 medication, like, if he's saying -- yes, I

1 would say if he skips a dose, he notices more
2 pain.

3 Q. All right. "Standing in one place or
4 too much activity and long car rides," again,
5 do you have any recollection of what he meant
6 by long car rides there?

7 A. I do not.

8 Q. Okay. That's all right.

9 The pain on the VAS scale, 3 and -- out
10 of 10, what -- tell me how you -- how you rate
11 that and how you present that to the patient.

12 A. You know what I do have? Is this May
13 21st?

14 Q. Yes, Ma'am.

15 A. He does write on his intake, he says, he
16 is "stiff and slow getting around in the
17 morning and loosens during the day. Standing
18 for more than 15 to 20 minutes is the limit I
19 have."

20 Q. Okay.

21 A. "I have to sit down. Walking, I can go
22 30 minutes to an hour and then sit down. By
23 midday, the back pain will leave, and I have no
24 symptoms, but foot pain remains."

25 Q. Doctor, I didn't ever get those intake

1 pages.

2 A. I can get those to you. That's just --
3 what we tend to do is when a patient is
4 sitting, about to come back, they'll write, you
5 know, the information that we ask.

6 Q. I understand. Did he write anything
7 about driving there?

8 A. He just mentions --

9 Q. Long car rides?

10 A. No. Just about having to sit down --
11 standing more than -- no, he does not.

12 Q. Okay. And then back to my question with
13 regards to the pain, 3 on a scale of 10 --

14 A. Yes.

15 Q. -- tell me how that is presented to the
16 patient and how do you analyze that?

17 A. Well, the more -- the more accurate way
18 to analyze is a lot of times a visual analog
19 scale, people learn it almost like they learn
20 their Social Security number, what's your pain
21 today, it's a 10. It's, like, that's the worst
22 pain ever, it's a 10. You know, that's kind of
23 how they are.

24 Really, the more accurate way is to use
25 a scale such as this but, actually, it be, you

1 know, 10 inches or 10 centimeters and where
2 they put their X on the scale should actually
3 be measured. And then you have a measured
4 reading based upon -- on a line where their
5 pain tends to sit. And that can help you. And
6 that's probably a little bit more accurate
7 because where they put it, they don't memorize
8 where they are on the line.

9 Q. Sure, sure.

10 A. And that's actually a little bit more
11 accurate than using a number. But a three is
12 pretty well-controlled pain as a whole.

13 Q. Okay. Then the next visit, if I've got
14 this right, is August 22nd.

15 A. I have it as August 22nd as well.

16 Q. Okay. There he's reporting that his
17 functionality has decreased. Did you do
18 anything in terms of your evaluation that
19 either confirmed or refuted that, or do you try
20 to do that?

21 A. We use a lot of their report, their
22 self-report as a means of figuring it out.

23 Sometimes when something changes
24 considerably, we will kind of watch what
25 they're doing or whatever. But we -- we use

1 actually functionality more than the VAS, the
2 score, because, again, like you said, one's
3 just a number. Whereas, I'm not doing -- I
4 hurt more, I haven't been able to do as much, I
5 can't go to the mailbox, I can only get around
6 in the kitchen and I have to sit, that sort of
7 thing. So a lot of times they'll give us more
8 detailed report.

9 That's pretty vague except for he is now
10 walking with a cane, which looks like that's
11 something different.

12 Q. When he -- when he reported his
13 functionality was -- has decreased, did he give
14 you any more specifics than that?

15 A. He writes that he's same to worse, that
16 "Tramadol use goes up with activities. Hand
17 swelling in fingers hurt. Low back stiffness.
18 Pain in both heels and balls of feet and
19 grinding teeth," is what he wrote on his intake
20 form.

21 Q. So you didn't conduct any evaluation or
22 analysis yourself to determine if his
23 functionality had, in fact, decreased?

24 A. No.

25 Q. Okay. And as far as why he was -- why

1 he had bought a cane, do you know what -- what
2 specific physical problem led him to do that?
3 In other words, was it the pain in his feet, do
4 you know? Was it -- was it his balance? Was
5 it meds?

6 A. It's more the foot pain, I believe is
7 why he was using the cane.

8 Q. He -- you have it that he has a new
9 complaint of bilateral hands and feet. What
10 would that signify to you, if anything?

11 A. Well, I guess the one thing you always
12 want to look for is, like, peripheral
13 neuropathy, new onset diabetic, is there some
14 sort of thing going on, is there a vitamin
15 deficiency, you know, causes for peripheral
16 neuropathy as that pain.

17 But other times, when we see pain that
18 kind of is random, sometimes it can also be
19 more related to depression or other changes as
20 they -- again, that's the reason why I like
21 getting them to work sooner or do something
22 because when you sit around and dwell on your
23 pain, you notice more pain.

24 Q. Were you -- throughout this period of
25 time, do you counsel the patient to get out

1 and --

2 A. Yes.

3 Q. -- engage in exercise?

4 A. Always.

5 Q. And try to work?

6 A. Always.

7 Q. Did you -- were you having any success
8 in Mr. Bliss' --

9 A. He -- he -- his problem and the problem
10 pretty much from the beginning is that the
11 medications always helped him, but the sexual
12 side effects was causing a lot of problems in
13 his house. So every time that he would come
14 in, the main thing that he would be talking
15 about is erectile dysfunction.

16 So we would counsel, you know, getting
17 up and doing things and moving around and how
18 big a deal is this because if it's a big enough
19 deal, it is usually worth changing medication.

20 If a side effect is greater than its
21 benefit, we should absolutely change a
22 medication.

23 So his main focus -- I was never under
24 the impression -- usually when somebody is not
25 functional, he -- he described himself, I mean,

1 a 3 out of 10 pain, 80 to 90 percent
2 improvement. That's a pretty functional
3 person. So you're less likely to say, you know
4 what, you need to get out of your chair and
5 quit just watching TV. What do you do in the
6 day. And I'll see that more with somebody who
7 I feel is less functional. We will spend more
8 time on that discussion.

9 In his particular case, he never really
10 described decreased functionality until this
11 visit. So he was mainly describing the side
12 effects of the medication, although --
13 although, the medications were very helpful to
14 him.

15 Q. Okay.

16 A. And it would be more counseling in that
17 direction.

18 Q. So if I understand you correctly -- and
19 you correct me if I'm wrong -- basically you
20 felt that his activity level was probably high
21 enough that you didn't have to spend a lot of
22 time on encouraging him to work hardening and
23 those kinds of things?

24 A. Yes.

25 Q. All right. There was no indication to

1 you, at least through your analysis over these
2 months and your physical exams, that he was
3 incapable of engaging in normal activities?

4 A. No, there was no indication.

5 Q. All right. On page 32, under
6 assessment, you do reference encouraging him to
7 attend the YMCA and to increase his activities.
8 So at least there was some indication at that
9 point in time maybe you felt he should increase
10 his activity?

11 A. Yeah. And you can kind of see, he comes
12 in. He says he's less functional. He's using
13 a cane. Okay. How do we get him back, what
14 happened between those three months or the last
15 visit and how do we get him back to doing what
16 he was.

17 There's not a big fall or something that
18 changed significantly. Sometimes they just
19 need a little push to say, you know what, if
20 you're okay in the water, you're going to start
21 to be okay in land and you get moving again.

22 And he looks like he expresses interest
23 in trying to -- he recognizes it as well. And
24 is actually saying going to the Y with his son.
25 So he's proactively trying to do something,

1 which is also unusual with our patients so --

2 Q. Did you -- did you follow that up, or do
3 you know if he joined the Y or if he did any
4 aquatherapy?

5 A. I do not.

6 Q. Okay. As of that date of May -- or
7 August 21st -- excuse me, August 22nd, 2012,
8 you still had not imposed any specific
9 restrictions on Mr. Bliss; is that correct?

10 A. That is correct.

11 Q. And that -- is that the last time you've
12 seen him?

13 A. Yes, that I'm aware of.

14 Q. Okay. As of that date, what meds were
15 you prescribing for Mr. Bliss?

16 A. Cymbalta and Lyrica.

17 Q. And what is Cymbalta for?

18 A. Cymbalta is -- what it does is it
19 increases serotonin and norepinephrine, some
20 neurotransmitters that get depleted with pain.
21 It is an antidepressant, but we don't use it --
22 its indication is more for neuropathic pain.
23 And most of the time people in pain also have
24 some depression associated with it.

25 Q. He says he's taking up to six Tramadol a

1 day. Where is he getting that prescription?

2 A. That must be through his primary care.

3 Q. And what is Tramadol?

4 A. Tramadol is a -- it is a pain medication
5 that works at a narcotic receptor. It is --
6 it's schedule -- I don't remember its schedule
7 dosing.

8 But it doesn't -- it's not like
9 hydrocodone. So people sometimes will have
10 samples in their office or things like that.
11 It's a lot less regulated. But all intents and
12 purpose, it's a narcotic.

13 Q. Okay. And Lyrica?

14 A. Lyrica's an anticonvulsant. It works at
15 something called an alpha 2 delta receptor. So
16 what it's supposed to do is stabilize the way a
17 nerve sends a pain signal.

18 If you -- if you block the calcium
19 channel through there, you don't have pain.
20 So, again, it's for neuropathic pain is what we
21 use it for. Although, it's a anticonvulsant.

22 Q. How do you monitor his use of this
23 narcotic drug in conjunction with what you're
24 trying to do with your other drugs?

25 A. I -- I tend not -- I tend not to

1 prescribe narcotics very often for chronic
2 pain. How -- the only way that we tend to
3 monitor it is on an intake, asking the patient
4 what are they taking.

5 I don't try to second guess necessarily
6 their primary care unless I see a red flag or a
7 reason that they should be a little more aware
8 of something.

9 If I'm giving them a pain medication and
10 I find out someone else is, that's a definite
11 red flag. And that would be a reason.

12 But I've never given him as such a pain
13 pill. And so what his primary care is doing is
14 kind of between them.

15 Q. Okay. So this Tramadol, 100 milligrams,
16 four to six tablets daily --

17 A. That's an outrageous amount in my
18 personal opinion. But, again, I try not to
19 judge. It almost makes me question whether
20 that is the correct number or not. Because
21 that is a really high dose.

22 Q. I understand. And I guess that was my
23 question. Is -- is there any concern at this
24 point --

25 A. Yes.

1 Q. Okay.

2 A. See, initially on my initial ones, he
3 was on 100 milligrams. And this is another --
4 the way an extended-release medication works is
5 it is supposed to be slowly released by
6 whatever -- whatever substance that you want to
7 use to cause it over a certain period, whether
8 it be 12-hour, 24-hour.

9 I'm amazed by how often the medication
10 is not prescribed correctly. As 100 milligram,
11 that's an extended-release medication. Most
12 people, you'd never give that person in a 50
13 milligram form, whatever -- 10, 15 of those.
14 And, yet, you're somewhat doing that when
15 you're giving them three a day of 100
16 milligrams or six a day of a 100-milligram
17 pill.

18 Again, I question the judgment of that.
19 But I -- I'll just leave it at that.

20 Q. Okay. I understand. All right. You
21 didn't have any -- any -- you don't recall any
22 specific visits that you had with Mr. Bliss
23 concerning his narcotic medications?

24 A. No, I did not.

25 Q. Okay. All right.

1 A. The other thing that's really hard is
2 that oftentimes when they come from a
3 neurosurgeon or they come from a surgical
4 consult or standpoint, we're not necessarily
5 monitoring the primary care's care. So we're
6 just handling that part of it. So Dr. Lodhia
7 wasn't prescribing it, we're not prescribing
8 it, it is of concern.

9 Q. I understand. Do you know who's
10 prescribing it? I mean, for sure or --

11 A. I assume Dr. Kreshel because that's who
12 his primary care is. But I don't -- I'm
13 assuming. But I don't know.

14 Q. Okay. Any other medications that you're
15 aware of that he's taking?

16 A. No, I'm not aware of any others.

17 Q. Now, at least as of November of 2011, he
18 had -- he was on hydrocodone. That could have
19 been through -- from the shoulder surgery or --

20 A. Yes, I would assume so.

21 Q. Okay.

22 A. I would assume so.

23 Q. All right. Next visit that you have is
24 scheduled for, like, three months from August;
25 is that right?

1 A. Yes.

2 Q. And why -- why do you have another visit
3 scheduled, and how long is -- what are your
4 plans? What is the prognosis and plans for
5 Mr. Bliss?

6 A. As a whole, somebody with chronic pain
7 needs to be seen at intervals -- and his
8 interval, it would probably be further apart.
9 If I saw him and he's still on Cymbalta at 60
10 or Lyrica at 100 three times a day or whatever
11 he's on and he's been stable like that for a
12 year or whatever, I'd probably extend those
13 visits to six months because there's not a
14 reason that we need to.

15 The -- the Tramadol use or things like
16 that may -- may make it so that it would be
17 valuable for him to come in sooner in a
18 situation like that.

19 Q. Got you.

20 Do you -- strike that.

21 You didn't have an opportunity to review
22 any MRIs or --

23 A. I have seen his MRIs before.

24 Q. Oh, have you?

25 A. Yes.

1 Q. Okay. The MRIs that reveal the lumbar
2 disc degeneration, the facet arthropathy, the
3 lumbar spinal stenosis, again, all of those
4 things can be attributable to simply a
5 degenerative process of the spine; correct?

6 A. Correct.

7 Q. And you saw those, I take it, on the
8 MRIs prior to -- of those MRIs prior to
9 February 3rd of 2011; correct?

10 A. Yes.

11 Q. That's a yes?

12 A. Yes.

13 Q. Okay. Doctor, you have been
14 identified -- and I don't know if I'm telling
15 you anything you don't know. But you've been
16 identified as a possible expert for the
17 plaintiffs in this case at trial. Were you
18 aware of that?

19 A. No, I was not.

20 Q. All right. You -- it is -- it is
21 suggested that you have some specific opinions
22 relative to functional limitations, medication
23 requirements and job restrictions. Is that --
24 is that -- based on what our earlier -- your
25 earlier testimony was, I take it that's not

1 entirely accurate?

2 A. Yeah, that is not entirely accurate.

3 Q. Okay. For example, do you know or do
4 you have opinions as to what his current
5 functional limitations are?

6 A. No, I do not.

7 Q. All right. Do you have opinions
8 relative to what his -- what, if any, job
9 restrictions he has?

10 A. It would only be based upon his prior
11 assessment.

12 Q. The FCE?

13 A. Uh-huh, yes.

14 Q. That FCE revealed a medium to heavy
15 work?

16 A. Correct.

17 Q. Okay. What about opinions as to his
18 pain? Do you have opinions as to whether
19 that -- well, let me back up.

20 As we sit here today, do you know what
21 specifically is causing Mr. Bliss' pain and
22 where it's located?

23 A. I would say it's multifactorial.

24 Q. Okay.

25 A. I would say that by the response he had

1 from his rhizotomy, that there is definitely a
2 facet or arthritis component to his pain.

3 I would say that based upon his EMG
4 studies, he has some chronic L5 radicular --
5 radiculopathy. And there might have been S1,
6 too. I'm not sure. But the EMG studies would
7 suggest.

8 So he's got both lower extremity pain
9 and back pain, which can be accounted for. And
10 then the MRI findings suggest some chronic
11 changes that way. Whether those are actually
12 the cause of his current pain, I'm not sure.

13 Q. Do you know what -- to what extent he is
14 having any pain, for example, in his knees and
15 what's causing the knee pain?

16 A. I do not.

17 Q. Foot pain we talked about or the hand
18 pain, we don't know if that is -- if there's
19 a -- what's the word for it? Physiological
20 reason --

21 A. We don't know.

22 Q. -- or if it's just -- okay.

23 What about shoulder pain? Do we know if
24 any of his current conditions are related to
25 his shoulder problems?

1 A. I do not know.

2 Q. Okay. I'm just about done, Doctor. Let
3 me look for --

4 A. You're fine.

5 Q. You would agree with me that Mr. Bliss
6 was clearly suffering from degenerative disc
7 disease prior to February 3rd of 2011?

8 A. Yes.

9 Q. The -- I think you've already told me,
10 the FCE appeared to be a valid FCE; correct?

11 A. Yes.

12 MR. LUERS: Doctor, thank you.
13 That's all the questions I have.

14 THE WITNESS: Thank you.

15 CROSS-EXAMINATION

16 BY MR. McMAHON:

17 Q. Just a few, Doctor. Following up on
18 some of the questions regarding any opinions
19 that you might have, work restrictions or
20 whatnot.

21 Since I'm his attorney and I'm the one
22 that disclosed it, let me show you a document.

23 MR. McMAHON: I guess we should
24 mark this as Exhibit 52.

25 ///

1 (Exhibit No. 52 marked for
2 identification.)

3 Q. (BY MR. McMAHON) Doctor, you recognize
4 your signature is on this document?

5 A. Yes.

6 Q. Okay. Do you recall filling out this
7 document for Mr. Bliss? I think it's dated
8 January 27th, 2012.

9 A. Yes.

10 Q. Okay. And --

11 A. I did not -- I didn't fill it out,
12 though.

13 Q. Okay. You didn't fill it out?

14 A. That is actually our work comp nurse
15 that filled it out.

16 Q. Although your name is dated in the box
17 No. 7?

18 A. Yes, yes.

19 Q. Your name is included in there?

20 A. I did -- I must have read over it to
21 sign it.

22 Q. So you must have reviewed this when you
23 signed the document?

24 A. Yes.

25 Q. Okay. And do you hold the opinions that

BNSF objects to
the testimony as
hearsay without
an exception
and as not
relevant. Fed.
R. Evid. 402,
403, 801 and
802.

Ruling: Overruled

1 are listed here that were submitted with this
2 form on January 27th, 2012?

3 A. Yes.

4 Q. And on those forms, you both gave your
5 diagnosis and the diagnosis -- working
6 diagnosis that you had at the time; is that
7 correct?

8 A. Yes.

9 Q. And you attached medical records that we
10 just went over in great detail to this -- to
11 this document; is that right?

12 A. Yes.

13 Q. And you indicated some of the past
14 surgeries and medical history that Mr. Bliss
15 had undergone; is that correct?

16 A. Correct.

17 Q. Box No. 3.

18 Box No. 5 was -- asked your opinion
19 regarding his ability to return to work. And
20 on that you said that he's not able to return
21 to work but he needs light to sedentary work,
22 which agrees with the opinions that were
23 revealed in your medical records; correct?

24 A. Yes.

25 Q. And you stated on earlier questions that

1 it's your understanding just through your work
2 experience, that the railroad carman position
3 doesn't have a light or sedentary work
4 assignment, but it was your opinion that he
5 could return to work at the railroad in a light
6 or sedentary position; correct?

7 A. Yes.

8 Q. And both -- you testified that, in fact,
9 that is good for a patient like Mr. Bliss who
10 has chronic pain to be out and doing some type
11 of employment even if it's in a sedentary type
12 of position?

13 A. Yes.

14 Q. And in your experience with -- in these
15 type of work comp -- work injury type of
16 situations, I should say, do you find that
17 employers are typically receptive of accepting
18 employees back with the -- with these types of
19 restrictions?

20 A. Depends on the job. Depends on the
21 employment. If it's not available, it's not
22 available. I mean, a construction worker may
23 not be able to go back to construction, and if
24 they don't have a desk job available, they may
25 need to find a different type of employment.

1 But as a whole, try to accommodate them.

2 Q. Okay. And so a reasonable employer
3 would try to accommodate these types of
4 restrictions?

5 A. Again, depends on the type of
6 employment --

7 MR. LUERS: Object to form of
8 the question.

9 A. -- they have.

10 Q. ~~(BY MR. McMAHON) Right. Okay. Did you~~
11 ~~know that BNSF had terminated Mr. Bliss at or~~
12 ~~maybe a few days before he -- first seeing him?~~

13 A. ~~No, I wasn't aware.~~

14 Q. Okay. And -- all right. And so Exhibit
15 52, do you still hold these opinions to a
16 reasonable degree of medical certainty, that
17 the -- the job restrictions that you would
18 place upon Mr. Bliss would be a light or
19 sedentary work assignment?

20 MR. LUERS: Object. Form and
21 foundation.

22 A. How -- just -- how the -- how this comes
23 about is we have a work comp nurse in the
24 office to review the chart and then to fill in
25 the lines.

BNSF objects to the question as to its improper form as to use of terms "reasonable employer" and "accommodate." **Ruling: Sustained, especially since the witness never answered the question as to this plaintiff and his employment.**

50:10-13 is stricken--See pretrial conference order and motion in limine ruling.

1 And I assume that she came to the light
2 to sedentary work restriction based upon the
3 note that was in the chart.

4 Do I think he is at 100 percent? No.

5 Do I really know where he falls on that?

6 I do not. I don't know off the top of my head.

7 I can look at a book and figure out what --

8 what the guidelines are for each of those
9 categories.

10 But she -- the person who filled out
11 this form does supposedly know both that and
12 the railroad and their normal restrictions and
13 the whole thing. So we tend to use their
14 expertise oftentimes in some of this portion of
15 it.

16 Q. (BY MR. McMAHON) Okay. So the -- so the
17 typical procedure in your office when you
18 have -- when you're called upon to -- in
19 your -- in your capacity as a physician, when
20 you're called upon to offer these types of
21 opinions like you did in Exhibit 52, the way
22 your office does it is you employ someone
23 who --

24 A. Has work comp expertise.

25 Q. -- has work comp expertise?

50:10 --53:3
BNSF objects to
the testimony as
hearsay without
an exception and
as not relevant.
Fed. R. Evid.
402, 403, 801
and 802. See
subsequent
testimony at 62:1
--63:8; 65:9-15.
Ruling:
Sustained. In
light of 7:12-8:14,
24:9-21, 44:3-16,
62:1 --63:8,
65:9-15, this
witness' testimony
as to level of work
the plaintiff can
perform and his
ability to return to
work at the
railroad is either
wholly irrelevant
for lack of
sufficient
foundation or, if
relevant at all,
more prejudicial
than probative.

1 A. Uh-huh.

2 Q. They review your treating notes?

3 A. Yes.

4 Q. And any other records they might have --

5 A. Yes.

6 Q. And then --

7 A. They render kind of their understanding
8 of it. And either we agree or disagree with
9 things.

10 And in this particular case, as I
11 understand -- well, as I understand secondhand
12 how the railroad works is that he could not be
13 a carman and that she's -- she's basically
14 saying, so less than 100 percent, the next
15 category from whatever full duty is is light
16 and -- or sedentary. And that's how it came
17 about.

18 Q. All right. And so when the -- this
19 process that you just described took place, you
20 endorsed that opinion?

21 A. Yes. Because, again, I didn't actually
22 do a functional capacity. I didn't actually
23 test him to figure that out.

24 But from how he presents in the office
25 and how -- what I -- my understanding of his

1 job duties, I did not believe that he could go
2 back to his current position. But I do think
3 he should work.

4 Q. Right. Absolutely. So -- so this
5 opinion that's reflected in Exhibit 52 where he
6 should be on a light or sedentary job
7 assignment, you still hold that opinion?

8 MR. LUERS: Object. Form and
9 foundation, asked and answered.

10 Q. (BY MR. McMAHON) You still hold that to
11 this day going forward?

12 MR. LUERS: Asked and answered.

13 A. As -- as of the last visit, I think it's
14 reasonable.

15 Q. (BY MR. McMAHON) And in the beginning
16 when Mr. Luers was talking about the documents
17 you have in your chart, I believe you had some
18 records from Dr. Lodhia?

19 A. Yes.

20 Q. And they're in the forms of letters to
21 Dr. Kreshel?

22 A. Yes.

23 Q. Then that September note, Dr. Lodhia had
24 both reviewed the FCE as well as the EMG as
25 well as met with Mr. Bliss; is that correct?

53:4 --54:1 BNSF objects to question as to its improper form. BNSF objects to the testimony as there is no proper and sufficient foundation; it is hearsay without an exception and not relevant. Fed. R. Evid. 402, 403, 801 and 802. See subsequent testimony at 62:1 --63:8; 65:9-15.
Ruling: Sustained as to 53:4-14 for the reasons stated as to 50:10-53:3; overruled as to 53:15-54:1

1 A. Yes.

2 MR. LUERS: Object on
3 foundation, as far as what Dr. Lodhia did.

4 Q. (BY MR. McMAHON) Okay. That's contained
5 in his records; correct?

6 A. Yes.

7 Q. And is nothing unusual for you to
8 receive records from a neurosurgeon or a
9 neurologist or other treating physician and you
10 use those records as part of your care and
11 treatment for patients; correct?

12 A. Yes.

13 Q. Okay. And that's what you did in this
14 case with Dr. Lodhia's records; correct?

15 A. Yes.

16 Q. Who was a referral physician, of course;
17 correct?

18 A. Yes.

19 Q. And it seems from that September 2011
20 note with Dr. Lodhia, that the FCE, as well as
21 Mr. Bliss' condition over this -- this summer
22 since the June 30th FCE, had worsened and his
23 condition -- the -- had -- he still had the
24 condition of back pain?

25 MR. LUERS: Object. Form and

1 foundation.

2 A. I lost track of your question.

3 Q. (BY MR. McMAHON) Sure. It seems the --
4 after the FCE and during the months when
5 Mr. Bliss was getting the diagnostic tests that
6 Dr. Lodhia had ordered, his back condition
7 had -- didn't improve? It was still -- he was
8 still symptomatic; correct?

9 MR. LUERS: Same objection,
10 foundation, form.

11 A. Yes.

12 Q. (BY MR. McMAHON) And Dr. Lodhia, in
13 fact, in that September 2011 visit recommended
14 that Mr. Bliss be in a light and -- light-duty
15 job assignment; correct?

16 A. Yes.

17 Q. In a permanent capacity?

18 MR. LUERS: Object. Foundation.

19 A. I don't know about that. But he does
20 say --

21 Q. (BY MR. McMAHON) Okay. All right. Part
22 of your -- part of the practice in pain
23 management, I guess how -- what I want to
24 phrase this more is there's a -- almost a --
25 the psychological and physiological response to

54:19 --55:18
BNSF objects to the question as to its improper form. BNSF objects to the testimony as there is no proper and sufficient foundation; it is hearsay without an exception and not relevant. Fed. R. Evid. 402, 403, 801 and 802. See subsequent testimony at 62:1 --63:8; 65:9-15
Ruling: Sustained for the reasons stated as to 50:10-53:3, plus the witness ultimately admitted she did not know what Dr. Lodhia recommended (55:12-20).

1 pain; is that correct?

2 A. Yes.

3 Q. All right. And while you were treating
4 Mr. Bliss, obviously there was a psychological
5 component to the chronic pain --

6 A. Pain condition.

7 Q. -- that he was treating; correct?

8 A. Correct.

9 Q. And that's -- although you're not a
10 psychiatrist or psychologist or whatnot,
11 that -- you incorporate those -- the mental
12 impacts of chronic pain in your treatment;
13 correct?

14 A. Yes.

15 Q. And you did that with Mr. Bliss?

16 A. Yes.

17 Q. All right. And part of that wasn't just
18 the mental anguish of chronic pain with
19 Mr. Bliss, but it was also affecting his
20 personal life. And you mentioned a little bit
21 about how that was impacting the medical care
22 and treatment, the medicine --

23 A. Yes.

24 Q. -- side that you were treating him with;
25 correct?

1 A. Yes.

2 Q. All right. And is that -- is that an
3 unusual type of --

4 A. No.

5 Q. It comes with the territory of treating
6 patients with chronic pain?

7 A. Yes.

8 Q. All right. And -- and that adjusting
9 the medications and trying to find the right
10 balance of the chronic pain medication that we
11 saw that you went through with Mr. Bliss, that
12 is -- that is what, I guess, the science and
13 the medicine of pain management is all about;
14 correct?

15 A. Yes.

16 Q. All right. And -- and fluctuating the
17 medications to try to help the patient deal
18 with the pain that's there on a permanent
19 basis; is that right?

20 A. Yes.

21 Q. And is that what you did with Mr. Bliss?

22 A. Yes.

23 Q. All right. And just real small point
24 that seemed to be made about the interesting
25 software of electronic medical records.

1 A. Yeah, I know.

2 Q. So --

3 A. There will be typos in there, too, that
4 will be, like, what in the world.

5 Q. This comes up a lot nowadays as EMR --

6 A. Unfortunately.

7 Q. Actually, I've been corrected. It's not
8 EMR. It's --

9 A. EHR.

10 Q. EHR. Stand corrected.

11 A. Yes. It's a health record now.

12 Q. So this work history reviewed, no
13 changes required, he works as a -- at BNSF as a
14 carman, this no changes required, that's not a
15 function of Mr. Bliss telling somebody, whether
16 it's you or the nurse, that no changes are
17 required from his perspective as a work
18 ability?

19 A. The no changes required comes up. What
20 happens is they are -- they're supposed to ask,
21 is -- is -- you still on the same medications,
22 has anything changed in terms of your social
23 status or your work status. And they say, no,
24 everything's the same from however they want to
25 recall it.

1 And then you click a box. And it says,
2 no change. And it fills that part out. And it
3 says, no change is required.

4 Q. So it's automatic?

5 A. So it's not somebody saying don't change
6 anything. It's just what it is.

7 Q. So if he came in and he got a job --

8 A. They should have taken that, and --

9 Q. Right.

10 A. -- it should have changed.

11 Q. Right.

12 A. He is now employed at blah, blah, blah.

13 Q. Blah, blah, blah. And that's when that
14 no change required would have changed and would
15 have --

16 A. Exactly. And it wouldn't be there then,
17 yes.

18 Q. Right. Okay. And the same for --
19 there's a -- there's a part -- I don't even
20 think it's a typo. It's more like a --

21 A. Unfortunately.

22 Q. It's a -- it's in the expectations line.

23 A. Uh-huh.

24 Q. And it seems to be more -- there must
25 have been, like, an update to the software.

1 It states here, "David further states,"
2 like, for example, on the --

3 A. Like, expectations, focus on remedy and
4 long-term effects or something?

5 Q. Yes.

6 A. Yes.

7 Q. So it seems like there's a second half
8 that's sort of filled in, but that first half
9 of the sentence is sort of -- is asked of the
10 patient, and it's just a way of tracking where
11 the patient is on that particular day?

12 A. It depends. Actually, sometimes it's
13 how the nurse chooses to fill in that line.
14 But we -- what -- what we require of them is
15 that the expectations for the visit because
16 sometimes patients will want to talk about
17 medication, or sometimes patients have a new
18 problem, I have a new pain complaint, my
19 shoulder hurts or something, I want to address
20 this instead of what -- what we expected them
21 to come in for.

22 So -- or I want an injection today. So
23 we know when we see them, this is what they
24 want. And whether we can accommodate or not is
25 another story. But that's what that line is.

1 Q. Good.

2 A. Is an expectation.

3 Q. Like another -- another way to flush out
4 all of the patient's needs and --

5 A. Absolutely.

6 Q. -- for a --

7 A. Try to make them happy however -- what
8 they want addressed.

9 Q. All right. Okay.

10 MR. McMAHON: Thank you, Doctor.
11 That's all I have.

12 REDIRECT EXAMINATION

13 BY MR. LUERS:

14 Q. Doctor, I have a few more.

15 A. I thought you might.

16 Q. Surprise. Certainly by the time you
17 signed Exhibit 52 --

18 A. Yes.

19 Q. -- you had seen the patient twice;
20 correct?

21 A. Yes.

22 Q. And both of those times your general
23 physical examination was virtually good, as you
24 told me; correct?

25 A. Yes.

1 Q. All right. And you told me, I believe,
2 that as of that December 21st visit, the
3 language there where you said, he's able to
4 work but not likely at full capacity and that
5 he would likely be qualified for light and
6 sedentary duty was likely the -- his words,
7 Mr. Bliss' words reporting to you; is that
8 accurate?

9 A. That is accurate.

10 Q. So the note that your -- that your nurse
11 or whomever was filling out, Exhibit 52, was
12 looking at is probably this note?

13 A. Based upon that.

14 Q. Okay. And I think you told me that your
15 belief was, at least -- or is, is that he's not
16 100 percent so he -- so he may not be able to
17 return to his normal employment; correct?

18 A. Yes.

19 Q. You're not analyzing based upon physical
20 demands of a job and the categories that --
21 that identify light, medium or heavy work in
22 your note of Exhibit 52; is that correct?

23 A. That's correct.

24 Q. And what you're saying is he -- he might
25 be -- or he'd likely be qualified for light or

1 sedentary duty. You're not saying there that
2 he would not necessarily be qualified for
3 medium duty?

4 A. That's correct too.

5 Q. All right. And you're just not
6 rendering opinions based upon functionality; is
7 that right?

8 A. That's correct.

9 Q. And we're still -- you're still -- it's
10 still your testimony that the only valid FCE
11 that you're aware of is that WorkWell FCE
12 and --

13 A. What -- but as an aside, when I get an
14 FCE and I've seen a patient and I've evaluated
15 him over time and I don't necessarily agree
16 with the FCE, the best time to have that
17 discussion or to state that is soon after it's
18 occurred.

19 And in his particular case, I think
20 after his FCE, he experienced more pain. And
21 that is when Dr. Lodhia saw him and kind of
22 assessed him and felt that maybe it's a little
23 different than how he presented at his FCE,
24 which is to say is that just a flare-up of his
25 condition or is it something more -- hard to

1 say.

2 Mine is just another blip in time, quite
3 a bit separate from the FCE. So, again, I'm
4 rendering opinion based on something current at
5 that moment.

6 So a functional capacity I always find
7 is a very helpful thing because you can
8 definitely -- most helpful when it's invalid
9 because you can kind of say -- but when it's a
10 valid FCE and the patient does their best and
11 then they walk away and they have more pain,
12 how long that pain lasts or what it is is --
13 sometimes it's reasonable to get or repeat if
14 you feel like something's changed.

15 Over the course of his history or his
16 physical exams, he -- when he came to us, he
17 was in pretty good shape. He didn't want a
18 spinal cord stimulator. He thought he could do
19 pretty well.

20 He started off doing really well in
21 terms of medication, despite the side effects
22 and pretty -- seemed fairly functional.

23 And then in the last couple of visits,
24 something kind of changed in terms of needing a
25 cane, wanting to figure out if he's just not

1 physically active. There's definitely some
2 depression and marital strife in all of that.
3 Something changed a little bit there.

4 Whether that's enough to warrant another
5 FCE, hard for me to say. But sometimes if
6 there's a question as to its validity from
7 prior to current, it may be reasonable to get
8 another one.

9 Q. I fully understand. And as you sit here
10 today, you're not going to render an opinion
11 that he's capable of returning to heavy-duty.
12 I understand that. But --

13 A. But the medium to light to sedentary
14 category, that's -- I'm not rendering an
15 opinion that way either.

16 Q. All right. And you don't know what it
17 is that in the last three months or why it is
18 in the last three months that maybe his
19 condition or functionality may have
20 deteriorated?

21 A. I don't. I don't.

22 Q. Okay. And you don't have any reason to
23 attribute that deterioration to an incident
24 that happened in February in 2011, do you?

25 A. No, that's not for me to say.

1 Q. Okay.

2 A. The one thing that is possible is that
3 he had the rhizotomy. He was doing pretty
4 well. Rhizotomy lasts on average six months to
5 two years, eighteen months average. It might
6 be the increased back pain or increased pain
7 that he's having, if he's mainly describing
8 back pain, may require another rhizotomy.

9 Q. Okay. But that wouldn't -- that
10 wouldn't result in a -- further reduction of
11 functionality, would it?

12 A. It should not.

13 Q. Okay. Right now his biggest limitation
14 is pain, I assume?

15 A. As I understand it.

16 Q. Okay.

17 MR. LUERS: Thank you, Doctor.
18 That's all I have.

19 THE WITNESS: Thank you.

20 MR. McMAHON: That's all I have.
21 Thank you, Doctor.

22 THE WITNESS: Thank you.

23 MR. LUERS: Oh, you know what,
24 can we get copies?

25 THE WITNESS: Yeah.

1 MR. LUERS: Could you make me a
2 quick copy of those?

3 THE WITNESS: Yeah.

4 MR. McMAHON: I don't have them
5 either.

6 THE WITNESS: Yeah, definitely.

7 MR. LUERS: Make two copies.
8 Make three copies. And we'll mark it real
9 quick so we know what we're talking about here.

10 THE WITNESS: These are these
11 pain diagrams.

12 MR. LUERS: Yes.

13 MR. McMAHON: With the --

14 MR. LUERS: The intake,
15 whatever.

16 (A short recess was taken.)

17 (Exhibit No. 53 marked for
18 identification.)

19 Q. (BY MR. LUERS) We're back on the record.
20 Doctor, I'm going to hand you what's been
21 marked as Exhibit 53. It's my understanding
22 that these were the -- sort of the intake notes
23 and then the -- what do you call these?
24 Clinical -- what do you call them?

25 A. It is a -- it is a patient intake and a

1 questionnaire.

2 Q. Okay. Fine. And that comes out of your
3 file today; is that right?

4 A. Correct.

5 MR. LUERS: That's all I have,
6 Doctor. Thank you.

7 MR. McMAHON: Fifty-three.

8 MR. LUERS: Doctor, you have a
9 right to read and review, or you can waive
10 that.

11 THE WITNESS: Waive.

12 (Deposition concluded at 2:21 p.m.)

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1 C-E-R-T-I-F-I-C-A-T-E

2 STATE OF NEBRASKA)

: ss.

3 COUNTY OF LANCASTER)

4 I, Lori J. McGowan, General Notary Public
5 in and for the State of Nebraska and Registered
6 Professional Reporter, hereby certify that DR.
7 LIANE DONOVAN was by me duly sworn to testify
8 the truth, the whole truth and nothing but the
9 truth, that the deposition by her as above set
10 forth was reduced to writing by me.

11 That the within and foregoing deposition
12 was taken by me at the time and place herein
13 specified and in accordance with the within
14 stipulations; the reading and signing of the
15 deposition having been waived.

16 That the foregoing deposition is a true
17 and accurate reflection of the proceedings
18 taken in the above case.

19 That I am not counsel, attorney, or
20 relative of either party or otherwise
21 interested in the event of this suit.

22 IN TESTIMONY WHEREOF, I place my hand and
23 notarial seal this day of October, 2012.

24

25

[& - assignment]

Page 1

&	24 40:8	8	adjusting 57:8
& 2:6	26 25:24	80 25:10 35:1	adls 26:25
0	27th 47:8 48:2	800 1:21	afternoon 3:18
0 3:22,22	28 27:16	9	age 3:13
1	2:21 68:12	9-19 14:22	agree 14:6 46:5 52:8
	3	9-2-11 10:14	63:15
10 29:10 30:13,21	3 2:3 29:9 30:13	9-26 15:3	agreed 3:2
30:22 31:1,1 35:1	35:1 48:17	9-9 13:21	agrees 48:22
40:13	30 29:22	90 25:10 35:1	alleged 19:17
100 7:23 39:15 40:3	30th 12:11 54:22	94 4:12	alleviated 16:4
40:10,15,16 42:10	32 36:5	95 16:17	alpha 38:15
51:4 52:14 62:16	3rd 19:14 43:9 46:7	9th 12:25	alternating 15:7
11-7-11 10:10	4	a	amazed 40:9
12 2:7 16:12 17:8	4 1:11	ability 27:2 48:19	amount 39:17
40:8	46 2:3	58:18	analog 30:18
12-21 20:6 22:13	47 2:8	able 22:23 23:9,20	analysis 32:22 36:1
1248 1:21	4:12cv3019 1:4	24:18 26:18 32:4	analyze 30:16,18
14 17:17	5	48:20 49:23 62:3,16	analyzing 62:19
15 29:18 40:13	5 14:23 48:18	absent 14:6	anguish 56:18
18 20:8	50 40:12	absolutely 34:21	answered 53:9,12
18th 17:16 19:9 20:2	51 2:6 12:18,23	53:4 61:5	anticipate 8:15
19 22:17	52 2:8 46:24 47:1	accepting 49:17	anticonvulsant
19th 25:17	50:15 51:21 53:5	accommodate 50:1	38:14,21
1:05 1:12	61:17 62:11,22	50:3 60:24	antidepressant
2	53 2:9 67:17,21	accounted 45:9	37:21
2 38:15	542 1:18	accurate 17:18 26:9	anybody 7:16
20 29:18	5th 21:17	26:14 30:17,24 31:6	apart 42:8
200 1:18	6	31:11 44:1,2 62:8,9	appearances 1:16
2003 4:19 11:5,15	6-30-11 9:11 11:2	69:17	appeared 46:10
201 1:13 3:24	60 42:9	acquainted 5:18	appears 12:11,24
2011 11:20 12:11,25	60605 1:19	6:25	april 25:17 26:24
13:21 16:25 19:14	61 2:3	active 65:1	aquatherapy 37:4
20:2 41:17 43:9	67 2:10	activities 8:12 27:1	area 21:6
46:7 54:19 55:13	68508 1:22	32:16 36:3,7	arthritis 15:13
65:24	6940 1:13 3:24	activity 26:19,23	16:20 28:7,17 45:2
2012 1:11 27:9 37:7	7	29:4 35:20 36:10	arthropathy 43:2
47:8 48:2 69:23	7 47:17	acute 25:14	aside 63:13
20th 24:25	7-13-11 10:21	add 18:15,19,22	asked 22:4 48:18
21st 20:18 21:20	7th 16:12,25	additional 17:1	53:9,12 60:9
27:9 29:13 37:7		address 3:23 21:2,8	asking 39:3
62:2		21:9 60:19	assessed 63:22
22 25:3		addressed 61:8	assessment 17:12
22nd 31:14,15 37:7			36:6 44:11
			assignment 49:4
			50:19 53:7 55:15

[associated - complaint]

Page 2

associated 5:10 37:24 assume 7:15 41:11 41:20,22 51:1 66:14 assuming 41:13 assumption 26:12 attached 48:9 attend 36:7 attention 21:14 attorney 1:17,20 7:1 46:21 69:19 attributable 43:4 attribute 65:23 attributed 14:14 august 31:14,15 37:7,7 41:24 automatic 59:4 available 49:21,22 49:24 average 66:4,5 aware 7:5,8,22 10:24 11:15,16,23 14:21 21:10,16 22:5 22:12 37:13 39:7 41:15,16 43:18 50:13 63:11	bed 28:8 began 4:19 beginning 34:10 53:15 begins 14:23 behalf 1:6 belief 27:6 62:15 believe 24:18 25:2 33:6 53:1,17 62:1 believed 18:20,21 benefit 34:21 best 24:6 26:13 63:16 64:10 better 22:21 25:11 big 34:18,18 36:17 biggest 66:13 bilateral 33:9 bit 17:20 31:6,10 56:20 64:3 65:3 blah 59:12,12,12,13 59:13,13 blip 64:2 bliss 1:3 5:21,24 6:9 7:1,7 9:5 11:14 12:12,25 13:17 14:20 19:3 20:3,7 34:8 37:9,15 40:22 42:5 44:21 46:5 47:7 48:14 49:9 50:11,18 53:25 54:21 55:5,14 56:4 56:15,19 57:11,21 58:15 62:7 block 15:24 38:18 bnsf 1:6 18:1 27:7 50:11 58:13 board 4:7 body 21:5 book 51:7 bottom 17:10 bought 33:1 box 47:16 48:17,18 59:1 branch 15:24	brought 21:14 burn 15:8 button 26:8 c c 69:1,1 calcium 38:18 call 67:23,24 called 38:15 51:18 51:20 cane 32:10 33:1,7 36:13 64:25 capabilities 12:13 capable 65:11 capacity 8:19 11:1 22:24 23:23 24:3,6 24:19 51:19 52:22 55:17 62:4 64:6 car 29:4,6 30:9 care 38:2 39:6,13 41:5,12 54:10 56:21 care's 41:5 carman 8:3 18:1,22 19:10,11 27:7 49:2 52:13 58:14 case 1:4 7:6 8:16 26:24 35:9 43:17 52:10 54:14 63:19 69:18 categories 24:12 51:9 62:20 category 52:15 65:14 cause 40:7 45:12 causes 28:15 33:15 causing 34:12 44:21 45:15 cautioned 3:13 centers 2:6 4:21 centimeters 31:1 certain 40:7 certainly 16:23 61:16 certainty 50:16	certified 3:14 4:7 certify 69:6 chair 35:4 change 18:16,17,18 19:6 20:13 23:7 26:13 34:21 59:2,3 59:5,14 changed 23:1 27:5 36:18 58:22 59:10 59:14 64:14,24 65:3 changes 17:25 18:5 18:8 31:23 33:19 45:11 58:13,14,16 58:19 changing 4:16 34:19 channel 38:19 chart 50:24 51:3 53:17 chicago 1:19 chooses 60:13 chronic 23:24 39:1 42:6 45:4,10 49:10 56:5,12,18 57:6,10 clearly 46:6 click 59:1 client 11:19 clinic 4:13 5:5 clinical 2:9 67:24 come 9:18 13:12,14 30:4 34:13 41:2,3 42:17 60:21 comes 26:16 36:11 50:22 57:5 58:5,19 68:2 comment 23:2 comments 22:18 23:5 comp 9:22 47:14 49:15 50:23 51:24 51:25 company 1:6 compilation 12:21 complaining 16:6 complaint 33:9 60:18
---	--	--	---

[complaints - dr]

Page 3

complaints 15:1 20:4,16 complete 12:21 component 45:2 56:5 concentrate 22:8 concern 23:9 39:23 41:8 concerning 40:23 concluded 68:12 condition 14:24 16:21 27:24 54:21 54:23,24 55:6 56:6 63:25 65:19 conditions 45:24 conduct 32:21 conducted 9:4 conducting 8:19 confirmed 31:19 conjunction 38:23 considerably 22:21 25:11 31:24 construction 49:22 49:23 consult 41:4 contained 54:4 continue 23:10,22 24:5,8,19 controlled 31:12 copies 66:24 67:7,8 copy 67:2 cord 6:4 64:18 correct 4:1,2,4 8:8,9 9:12 13:19 15:1 17:2,3,14,19 18:24 19:15,18 20:13,14 25:1,11,12,20 35:19 37:9,10 39:20 43:5 43:6,9 44:16 46:10 48:7,15,16,23 49:6 53:25 54:5,11,14,17 55:8,15 56:1,7,8,13 56:25 57:14 61:20 61:24 62:17,22,23 63:4,8 68:4	corrected 58:7,10 correctly 35:18 40:10 counsel 33:25 34:16 69:19 counseling 35:16 county 69:3 couple 64:23 course 54:16 64:15 court 1:1 covered 21:5 crafts 7:20 cross 2:2 46:15 cs1336570 1:25 current 15:7 44:4 45:12,24 53:2 64:4 65:7 currently 18:14,14 18:16 cymbalta 37:16,17 37:18 42:9	defendant 1:6,7,22 deficiency 33:15 definite 39:10 definitely 45:1 64:8 65:1 67:6 degenerates 16:9 degeneration 14:12 14:15 15:21 43:2 degenerative 15:20 43:5 46:6 degree 50:16 delivery 3:5 delta 38:15 demand 62:20 depends 49:20,20 50:5 60:12 depleted 37:20 deposition 1:5,10 3:4,5 5:12 9:15 10:3 68:12 69:9,11,15,16 depositions 9:25 depression 33:19 37:24 65:2 described 18:10 34:25 35:10 52:19 describing 35:11 66:7 desk 49:24 despite 64:21 detail 48:10 detailed 32:8 deteriorated 65:20 deterioration 65:23 determine 32:22 devney 5:4 11:18 12:15,22,24 13:3,4 13:12,23 14:19 devney's 11:16 13:18 diabetic 33:13 diagnosis 48:5,5,6 diagnostic 15:24 55:5 diagram 20:22	diagrams 67:11 dictate 19:6 different 32:11 49:25 63:23 direct 2:2 3:16 direction 35:17 directions 17:11 disable 23:25 disabled 18:14,16 18:22 disagree 52:8 disc 14:12 16:3 28:14 43:2 46:6 disclosed 46:22 discomfort 17:12 discuss 21:2 discussion 35:8 63:17 disease 46:7 distance 25:6,7 distress 25:14 district 1:1,2 doctor 3:18,25 5:12 12:20 14:7 15:6 26:4 29:25 43:13 46:2,12,17 47:3 61:10,14 66:17,21 67:20 68:6,8 doctor's 2:8 document 46:22 47:4,7,23 48:11 documents 11:6 53:16 doing 22:20 25:13 25:15 27:3 31:25 32:3 34:17 36:15 39:13 40:14 49:10 64:20 66:3 donovan 1:10 2:3 3:12,22 69:7 dorn 1:13 3:24 dose 29:1 39:21 dosing 38:7 dr 1:10 2:3 3:12 5:4 6:19,21 10:4,7,11
--	---	--	---

[dr - full]

Page 4

10:15 11:4,16,18 12:15,22,24 13:3,4 13:4,11,18,23 14:19 27:12 41:6,11 53:18 53:21,23 54:3,14,20 55:6,12 63:21 69:6 draw 20:23 driving 30:7 drug 38:23 drugs 38:24 duly 3:13 69:7 duties 7:20 53:1 duty 23:15 24:4,15 52:15 55:14 62:6 63:1,3 65:11 dwel 33:22 dysfunction 34:15	50:6 62:17 emr 58:5,8 encouraging 35:22 36:6 endorsed 52:20 engage 8:13 34:3 engaging 36:3 entirely 44:1,2 erectile 34:15 essay 5:3 evaluate 9:1 evaluated 63:14 evaluation 6:3 11:2 12:12 31:18 32:21 evaluations 8:20 evening 27:22 event 69:21 everything's 58:24 exacerbated 25:5 28:21 exactly 24:21 59:16 exam 14:2,7 23:6 25:14,18 examination 3:16 46:15 61:12,23 examined 3:15 example 8:2 44:3 45:14 60:2 exams 36:2 64:16 exception 14:4 excuse 37:7 exercise 25:22 26:1 26:2,19,23 34:3 exhibit 12:17,18,23 46:24 47:1 50:14 51:21 53:5 61:17 62:11,22 67:17,21 exhibits 2:5 expectation 61:2 expectations 59:22 60:3,15 expected 60:20 experience 49:2,14 experienced 63:20	expert 8:7 43:16 expertise 51:14,24 51:25 expresses 36:22 extend 42:12 extended 40:4,11 extent 45:13 extremities 17:14 extremity 45:8	file 68:3 fill 47:11,13 50:24 60:13 filled 47:15 51:10 60:8 filling 47:6 62:11 fills 59:2 find 39:10 49:16,25 57:9 64:6 finding 23:7 26:20 findings 45:10 fine 22:9 46:4 68:2 fingers 32:17 first 3:13 5:19 6:2,3 12:24 17:17 23:2 27:21 50:12 60:8 flag 39:6,11 flare 63:24 fluctuating 57:16 flush 61:3 focus 21:6 34:23 60:3 focused 22:4 follow 2:9 37:2 following 46:17 follows 3:15 foot 14:5 29:24 33:6 45:17 foregoing 69:11,16 form 3:10 9:19 26:16 32:20 40:13 48:2 50:7,20 51:11 53:8 54:25 55:10 forms 2:10 48:4 53:20 forth 69:10 forward 53:11 foundation 3:10 19:3 50:21 53:9 54:3 55:1,10,18 four 21:21,22 39:16 fourth 16:16 frankly 27:11 full 3:20 17:11 22:24 24:3 52:15
e		f	
e 1:10 2:1 3:12 69:1 69:1 earlier 43:24,25 48:25 edema 17:13 effect 34:20 effects 34:12 35:12 60:4 64:21 ehr 58:9,10 eighteen 66:5 either 18:20 31:19 52:8 65:15 67:5 69:20 electronic 26:6 57:25 eligible 24:12 emg 10:5,19,24 45:3 45:6 53:24 employ 51:22 employed 59:12 employees 7:13 49:18 employer 50:2 employers 49:17 employment 17:21 19:14 49:11,21,25		f 69:1 facet 14:12 15:9,12 15:13,21 16:6,8 43:2 45:2 facets 28:10 fact 32:23 49:8 55:13 factor 28:2 fairly 12:21 64:22 fall 36:17 falls 51:5 familiar 5:15 7:17 7:20 8:22 family 6:12,13 17:21 far 17:4,6 32:25 54:3 fce 12:2 44:12,14 46:10,10 53:24 54:20,22 55:4 63:10 63:11,14,16,20,23 64:3,10 65:5 fc 8:18 february 19:14 43:9 46:7 65:24 feel 35:7 64:14 feeling 27:2,22 feels 15:16 feet 32:18 33:3,9 felt 35:20 36:9 63:22 fifty 68:7 figure 51:7 52:23 64:25 figuring 31:22	

[full - kinds]

Page 5

62:4 fully 65:9 function 58:15 functional 8:19 11:1 34:25 35:2,7 36:12 43:22 44:5 52:22 64:6,22 functionality 31:17 32:1,13,23 35:10 63:6 65:19 66:11 further 42:8 60:1 66:10	h half 60:7,8 hand 32:16 45:17 67:20 69:22 handling 41:6 hands 33:9 happened 36:14 65:24 happens 58:20 happy 61:7 hard 7:24 41:1 63:25 65:5 hardening 35:22 head 51:6 health 58:11 heavy 24:15 44:14 62:21 65:11 heels 32:18 help 31:5 57:17 helped 34:11 helpful 35:13 64:7,8 hereinafter 3:14 high 35:20 39:21 history 11:14,24 17:22,23 18:10 20:13 22:14 25:4 27:10,18 48:14 58:12 64:15 hold 47:25 50:15 53:7,10 home 24:1 hope 12:21 hour 29:22 40:8,8 house 34:13 huh 13:24 16:14 17:9 27:17 44:13 52:1 59:23 hurt 32:4,17 hurts 60:19 hydrocodone 38:9 41:18	i identification 12:19 47:2 67:18 identified 43:14,16 identify 62:21 il 1:19 impacting 56:21 impacts 56:12 implies 26:17 impose 14:19 17:1 24:23 imposed 37:8 imposing 18:7 impression 14:10 34:24 improve 55:7 improved 22:15 improvement 35:2 incapable 36:3 inches 31:1 incident 65:23 included 14:10 47:19 incorporate 56:11 increase 36:7,9 increased 66:6,6 increases 37:19 independent 5:24 indicate 27:4 indicated 48:13 indication 16:24 20:1,15 21:20 35:25 36:4,8 37:22 indicative 16:19 individual 8:11,12 information 18:3 19:4 30:5 initial 13:22 14:18 19:23 20:1 40:2 initially 40:2 injection 60:22 injury 19:17 49:15 instance 19:8	intake 19:12 20:20 29:15,25 32:19 39:3 67:14,22,25 intent 15:14 intents 38:11 interest 24:7 36:22 interested 69:21 interesting 26:5 57:24 interval 42:8 intervals 42:7 invalid 64:8 involved 7:14 8:18 11:18 involving 7:6
g gait 26:14 general 7:23 14:1 28:5 61:22 69:4 generally 9:1 14:24 getting 28:2 29:16 33:21 34:16 38:1 55:5 give 21:19 32:7,13 40:12 given 39:12 giving 39:9 40:15 go 17:16 20:6 22:23 25:17 29:21 32:5 49:23 53:1 goes 32:16 going 12:16 23:22 26:7 33:14 36:20,24 53:11 65:10 67:20 good 3:18 11:6 13:9 15:25 25:19 49:9 61:1,23 64:17 great 27:22 48:10 greater 34:20 grinding 32:19 guess 22:3 28:21 33:11 39:5,22 46:23 55:23 57:12 guidelines 51:8	g gait 26:14 general 7:23 14:1 28:5 61:22 69:4 generally 9:1 14:24 getting 28:2 29:16 33:21 34:16 38:1 55:5 give 21:19 32:7,13 40:12 given 39:12 giving 39:9 40:15 go 17:16 20:6 22:23 25:17 29:21 32:5 49:23 53:1 goes 32:16 going 12:16 23:22 26:7 33:14 36:20,24 53:11 65:10 67:20 good 3:18 11:6 13:9 15:25 25:19 49:9 61:1,23 64:17 great 27:22 48:10 greater 34:20 grinding 32:19 guess 22:3 28:21 33:11 39:5,22 46:23 55:23 57:12 guidelines 51:8	j j 1:17 69:4 james 1:20 january 47:8 48:2 jim 3:18 job 1:25 7:20 8:3 23:20,21 24:4 43:23 44:8 49:20,24 50:17 53:1,6 55:15 59:7 62:20 john 5:3 joined 37:3 joint 15:8,9,16 16:1 16:6,8 judge 39:19 judgment 40:18 jumps 12:5 june 12:11 54:22	k keep 23:21 keeps 4:16 kind 16:23 23:21 27:24 28:9,11 30:22 31:24 33:18 36:11 39:14 52:7 63:21 64:9,24 kinds 8:16 27:23 35:23

[kitchen - morning]

Page 6

kitchen 32:6 knee 45:15 knees 45:14 know 4:16 5:18 6:16 6:17 8:1,2 13:7 17:4 17:6 22:9 26:15 29:12 30:5,22 31:1 33:1,4,15 34:16 35:3 36:19 37:3 41:9,13 43:14,15 44:3,20 45:13,18,21 45:23 46:1 50:11 51:5,6,11 55:19 58:1 60:23 65:16 66:23 67:9 knowledge 7:12 known 6:11 22:6 kreshel 10:11,15 41:11 53:21	53:6 55:14,14 62:5 62:21,25 65:13 limit 29:18 limitation 66:13 limitations 18:7 43:22 44:5 limited 27:2 lincoln 1:14,22 4:3 8:5 line 17:22 31:4,8 59:22 60:13,25 lines 50:25 listed 48:1 litigation 22:2,5 little 17:20 31:6,10 36:19 39:7 56:20 63:22 65:3 live 22:22 living 27:1 located 44:22 lodhia 6:19,21 10:7 13:11 27:12 41:6 53:18,23 54:3,20 55:6,12 63:21 lodhia's 10:4 54:14 long 4:10 25:5,7 29:4,6 30:9 42:3 60:4 64:12 longstanding 14:14 look 9:1 13:21 22:17 25:3 26:10 28:11 33:12 46:3 51:7 looking 28:9,10 62:12 looks 9:10 11:19 14:1 22:14 32:10 36:22 loosens 29:17 lori 69:4 loss 14:4,5 lost 55:2 lot 21:3 30:18 31:21 32:7 34:12 35:21 38:11 58:5	low 14:11 32:17 lower 17:13 45:8 luers 1:20 3:17,19 12:16,20 19:4 46:12 50:7,20 53:8,12,16 54:2,25 55:9,18 61:13 66:17,23 67:1 67:7,12,14,19 68:5 68:8 lumbar 14:11,12 17:10 43:1,3 lying 28:8 lyrica 37:16 38:13 42:10 lyrica's 38:14	mediated 15:13 28:15 medical 2:6 11:14 11:23,24 13:18 26:6 48:9,14,23 50:16 56:21 57:25 medication 28:25 34:19,22 35:12 38:4 39:9 40:4,9,11 43:22 57:10 60:17 64:21 medications 34:11 35:13 40:23 41:14 57:9,17 58:21 medicine 4:6 56:22 57:13 medium 24:13,20 44:14 62:21 63:3 65:13 meds 25:10 28:21,22 33:5 37:14 members 6:11,12 memorize 31:7 mental 56:11,18 mentioned 56:20 mentions 30:8 met 6:2,3 53:25 midday 29:23 mild 17:12 milligram 40:10,13 40:16 milligrams 39:15 40:3,16 mind 26:3 mine 64:2 minute 13:6 minutes 29:18,22 moment 64:5 monitor 38:22 39:3 monitoring 41:5 months 36:2,14 41:24 42:13 55:4 65:17,18 66:4,5 morning 27:21 28:6 28:7,11 29:17
I	I	m	
I 2:3 3:1 I5 45:4 lancaster 69:3 land 36:21 language 62:3 lasts 64:12 66:4 law 1:17,20 lawful 3:13 lawsuit 7:6 lawsuits 7:14 learn 30:19,19 leave 29:23 40:19 led 33:2 left 14:5 letter 10:10,14 letters 53:20 level 15:20,21 35:20 liane 1:10 3:12,22 69:7 life 56:20 lift 24:17 light 23:15 24:4,13 24:20 48:21 49:3,5 50:18 51:1 52:15	located 44:22 lodhia 6:19,21 10:7 13:11 27:12 41:6 53:18,23 54:3,20 55:6,12 63:21 lodhia's 10:4 54:14 long 4:10 25:5,7 29:4,6 30:9 42:3 60:4 64:12 longstanding 14:14 look 9:1 13:21 22:17 25:3 26:10 28:11 33:12 46:3 51:7 looking 28:9,10 62:12 looks 9:10 11:19 14:1 22:14 32:10 36:22 loosens 29:17 lori 69:4 loss 14:4,5 lost 55:2 lot 21:3 30:18 31:21 32:7 34:12 35:21 38:11 58:5	ma'am 7:5 29:14 mailbox 32:5 main 34:14,23 management 55:23 57:13 march 24:25 marital 65:2 mark 12:16 16:13 20:23 46:24 67:8 marked 2:5 12:18 12:23 21:7 47:1 67:17,21 massey 5:3 matter 13:15 mcgowan 69:4 mcmahon 1:17 19:2 46:16,23 47:3 50:10 51:16 53:10,15 54:4 55:3,12,21 61:10 66:20 67:4,13 68:7 mean 18:15 21:7 26:23 34:25 41:10 49:22 means 31:22 meant 29:5 measured 31:3,3 medial 15:23	

[motion - paragraph]

Page 7

motion 15:16 17:11 moving 34:17 36:21 mri 45:10 mr 42:22,23 43:1,8 43:8 multi 15:20,21 multifactorial 44:23 multiple 22:2 musculoskeletal 25:23	40:12 new 26:20 33:8,13 60:17,18 noble 11:4 noon 27:21 norepinephrine 37:19 normal 14:8 16:10 17:14 26:8,14,19,23 36:3 51:12 62:17 normally 26:25 notarial 69:23 notary 69:4 note 25:14 51:3 53:23 54:20 62:10 62:12,22 noted 10:7 17:13 notes 3:8 10:4,7,17 11:16 12:22 52:2 67:22 notice 3:4,5 33:23 notices 29:1 november 16:12,25 17:16 19:9 20:2 41:17 nowadays 58:5 npc 2:9 number 30:20 31:11 32:3 39:20 nurse 9:22 20:21 47:14 50:23 58:16 60:13 62:10	offer 51:20 offered 2:5 offering 8:15 office 3:23 6:5 12:22 38:10 50:24 51:17 51:22 52:24 officially 4:18 oftentimes 41:2 51:14 oh 9:16 22:7 42:24 66:23 okay 4:13,17,22 5:4 5:9 6:5 7:9,12,19 8:1,7 9:4,21,23 10:12,16,25 11:10 11:22 12:15 14:17 15:22 16:2 17:7,20 18:19 19:8,22 20:25 21:10,19,25 22:7,13 23:11 24:9,20,22 25:9,17 26:22 27:4 27:15 28:1,20 29:8 29:20 30:12 31:13 31:16 32:25 35:15 36:13,20,21 37:6,14 38:13 39:15 40:1,20 40:25 41:14,21 43:1 43:13 44:3,17,24 45:22 46:2 47:6,10 47:13,25 50:2,10,14 51:16 54:4,13 55:21 59:18 61:9 62:14 65:22 66:1,9,13,16 68:2 old 11:3,14 omaha 5:8 one's 10:10 32:2 ones 40:2 onset 33:13 op 11:3 operation 11:15 opinion 23:21 24:10 39:18 48:18 49:4 52:20 53:5,7 64:4 65:10,15	opinions 8:10,16 43:21 44:4,7,17,18 46:18 47:25 48:22 50:15 51:21 63:6 opportunity 11:13 12:2 42:21 ordered 55:6 original 15:1 outrageous 39:17 overview 19:23
n	n	o	p
n 2:1 3:1,22,22 name 3:20,21 4:20 5:19 47:16,19 name's 3:18 names 5:2 narcotic 38:5,12,23 40:23 narcotics 39:1 ne 1:22 nebraska 1:2,14 4:3 4:21 69:2,5 necessarily 18:11 21:7 23:5,6 39:5 41:4 63:2,15 need 35:4 36:19 42:14 49:25 needing 64:24 needs 42:7 48:21 61:4 negative 14:25 nerve 15:8 38:17 neurological 17:12 neurologist 54:9 neuropathic 37:22 38:20 neuropathy 33:13 33:16 neurosurgeon 41:3 54:8 neurotransmitters 37:20 never 7:3 21:14 22:8 34:23 35:9 39:12	o 1:21 3:1 object 50:7,20 53:8 54:2,25 55:18 objection 19:2 55:9 objections 3:9 objective 13:25 17:7 obviously 18:1 56:4 occurred 19:17 63:18 october 1:11 69:23	okay 4:13,17,22 5:4 5:9 6:5 7:9,12,19 8:1,7 9:4,21,23 10:12,16,25 11:10 11:22 12:15 14:17 15:22 16:2 17:7,20 18:19 19:8,22 20:25 21:10,19,25 22:7,13 23:11 24:9,20,22 25:9,17 26:22 27:4 27:15 28:1,20 29:8 29:20 30:12 31:13 31:16 32:25 35:15 36:13,20,21 37:6,14 38:13 39:15 40:1,20 40:25 41:14,21 43:1 43:13 44:3,17,24 45:22 46:2 47:6,10 47:13,25 50:2,10,14 51:16 54:4,13 55:21 59:18 61:9 62:14 65:22 66:1,9,13,16 68:2 old 11:3,14 omaha 5:8 one's 10:10 32:2 ones 40:2 onset 33:13 op 11:3 operation 11:15 opinion 23:21 24:10 39:18 48:18 49:4 52:20 53:5,7 64:4 65:10,15	p 3:1 p.m. 1:12 68:12 page 13:25 14:23 16:12 17:8,17 20:8 22:17 25:3,24 27:16 36:5 pages 13:22 16:13 30:1 pain 2:6 4:6,14,14 4:21 6:23 14:11 15:12,12,13,17,25 16:4,5,17,23 19:23 20:4,16,22 21:4 22:15,21 23:24 24:6 25:5,11 27:20,22 28:3,5,6,12,13,13,15 28:17,18,20 29:2,9 29:23,24 30:13,20 30:22 31:5,12 32:18 33:3,6,16,17,23,23 35:1 37:20,22,23 38:4,17,19,20 39:2 39:9,12 42:6 44:18 44:21 45:2,8,9,12 45:14,15,17,18,23 49:10 54:24 55:22 56:1,5,6,12,18 57:6 57:10,13,18 60:18 63:20 64:11,12 66:6 66:6,8,14 67:11 paragraph 19:25 25:4 27:10,18

[part - recommend]

Page 8

part 41:6 54:10 55:21,22 56:17 59:2 59:19 participate 26:2 particular 11:19 35:9 52:10 60:11 63:19 parties 3:3 party 69:20 patient 12:15 13:3,5 17:18 18:13,21 21:8 29:11 30:3,16 33:25 39:3 49:9 57:17 60:10,11 61:19 63:14 64:10 67:25 patient's 24:6 61:4 patients 6:23 15:19 21:4 37:1 54:11 57:6 60:16,17 pending 7:6,14 people 23:21 28:5 30:19 37:23 38:9 40:12 percent 7:23 16:17 25:10 35:1 51:4 52:14 62:16 perchance 25:6 perform 24:3 period 33:24 40:7 peripheral 33:12,15 permanent 55:17 57:18 person 35:3 40:12 51:10 personal 39:18 56:20 perspective 58:17 phil 5:3 phrase 55:24 physical 12:12,13 14:1,7 21:21 22:11 23:6 25:13,18 33:2 36:2 61:23 62:19 64:16	physically 65:1 physician 3:25 51:19 54:9,16 physicians 21:11 physiological 45:19 55:25 picture 20:22 pill 39:13 40:17 place 1:13 29:3 50:18 52:19 69:12 69:22 places 21:7 plaintiff 1:4,19 plaintiffs 43:17 plans 42:4,4 please 3:21 10:6 point 18:6 21:1 25:15 36:9 39:24 57:23 portion 15:15,25 17:7 51:14 position 49:2,6,12 53:2 possible 13:14 43:16 66:2 pounds 24:17 practice 4:22 5:1,7 8:19 55:22 practicing 4:3,10 precipitating 28:1 prescribe 39:1 prescribed 40:10 prescribing 37:15 41:7,7,10 prescription 38:1 presence 3:7 present 29:11 presented 30:15 63:23 presents 52:24 pretty 14:8 17:14 25:15,19 31:12 32:9 34:10 35:2 64:17,19 64:22 66:3	primary 38:2 39:6 39:13 41:5,12 prior 6:9 9:25,25 10:3,23 11:4,8,10 11:10 43:8,8 44:10 46:7 65:7 proactively 36:25 probable 23:11 probably 7:15 14:12 26:10,20 31:6 35:20 42:8,12 62:12 problem 20:17 33:2 34:9,9 60:18 problems 20:3 21:12 22:10 34:12 45:25 procedure 51:17 proceeded 15:3 proceedings 69:17 process 5:16 16:10 43:5 52:19 professional 69:6 prognosis 42:4 program 25:22 26:3 progresses 28:3,13 prove 15:24 provided 9:12,21 10:3,22 11:7 13:18 18:2 19:5 psychiatrist 56:10 psychological 55:25 56:4 psychologist 56:10 public 69:4 purpose 15:10 38:12 push 26:7 36:19 put 12:20 26:8 31:2 31:7	65:6 questionnaire 68:1 questions 46:13,18 48:25 quick 67:2,9 quit 35:5 quite 27:10 64:2
			r
			r 69:1 radicular 45:4 radiculopathy 45:5 radiofrequency 11:17 railroad 7:13,21 24:3 49:2,5 51:12 52:12 railway 1:6 random 33:18 range 15:16 17:11 rarely 8:21 rate 13:16 29:10 read 47:20 68:9 reading 31:4 69:14 real 57:23 67:8 really 9:16 30:24 35:9 39:21 41:1 51:5 64:20 reason 16:25 18:20 33:20 39:7,11 42:14 45:20 65:22 reasonable 50:2,16 53:14 64:13 65:7 recall 23:2,18 25:6,8 40:21 47:6 58:25 receive 54:8 receptive 49:17 receptor 38:5,15 recess 67:16 recognize 47:3 recognizes 36:23 recollection 5:24 29:5 recommend 24:7
		q	
		qualified 23:15 62:5 62:25 63:2 question 3:11 13:9 30:12 39:19,23 40:18 50:8 55:2	

[recommended - side]

Page 9

recommended 6:17 55:13 recommending 25:23 record 10:9 26:6,7 26:11 58:11 67:19 records 2:7 9:20 10:1,2 11:23 13:18 48:9,23 52:4 53:18 54:5,8,10,14 57:25 recross 2:2 red 39:6,11 redirect 2:2 61:12 reduced 69:10 reduction 16:17,24 66:10 refer 13:4 reference 20:12 36:6 referenced 25:7 referral 6:18 27:11 54:16 referrals 6:21 reflected 53:5 reflection 69:17 reflexes 14:6 refuted 31:19 regarding 11:16 46:18 48:19 regards 12:1 27:5 30:13 registered 69:5 regulated 38:11 related 15:12,25 16:6,20 28:7,18 33:19 45:24 relative 43:22 44:8 69:20 relatively 25:19 release 40:4,11 released 40:5 relief 25:10 remains 17:13 29:24 remedy 60:3	remember 9:14 13:10 38:6 remove 15:15 18:17 render 8:10 52:7 65:10 rendering 24:10 63:6 64:4 65:14 repeat 64:13 report 9:1 11:3 13:22 14:19,22 19:25 20:15 31:21 31:22 32:8 reported 32:12 reporter 69:6 reporting 31:16 62:7 reports 16:17 request 9:24,25 require 60:14 66:8 required 17:25 18:5 18:9,16 58:13,14,17 58:19 59:3,14 requirements 8:3 43:23 reserved 3:9 response 44:25 55:25 restricted 18:25 restriction 51:2 restrictions 14:20 17:1,5 18:7,11 24:23 37:9 43:23 44:9 46:19 49:19 50:4,17 51:12 result 66:10 return 7:24 8:11 18:21 19:10 27:23 28:16 48:19,20 49:5 62:17 returning 65:11 reveal 43:1 revealed 44:14 48:23 review 11:13 12:3 42:21 50:24 52:2	68:9 reviewed 47:22 53:24 58:12 rhizotomy 15:4,14 45:1 66:3,4,8 rides 29:4,6 30:9 right 5:9,15 6:1,6,15 6:25 7:3 8:22 9:7 10:2 11:20 12:1,10 14:22 17:16 20:12 24:25 28:20 29:3,8 31:14 35:25 36:5 40:20,25 41:23,25 43:20 44:7 48:11 50:10,14 52:18 53:4 55:21 56:3,17 57:2 57:8,9,16,19,23 59:9,11,18 61:9 62:1 63:5,7 65:16 66:13 68:3,9 rule 28:5 run 8:23	seal 69:23 second 13:25 25:4 25:24 27:10,18 39:5 60:7 secondhand 52:11 secretary 18:13,13 security 24:11 30:20 sedentary 23:15 48:21 49:3,6,11 50:19 51:2 52:16 53:6 62:6 63:1 65:13 see 13:13 21:5 22:1 33:17 35:6 36:11 39:6 40:2 60:23 seeing 50:12 seen 9:4 37:12 42:7 42:23 61:19 63:14 self 31:22 send 8:21,25 sends 38:17 sensation 14:5 sensory 15:15 sent 13:3 sentence 16:16,16 24:10 60:9 separate 64:3 september 11:20 12:25 53:23 54:19 55:13 serotonin 37:19 set 69:9 sexual 34:11 shape 64:17 shops 8:5 short 67:16 shoulder 20:3,16,16 20:23 21:12,17,23 22:10 41:19 45:23 45:25 60:19 shoulders 20:4 show 46:22 side 34:12,20 35:11 56:24 64:21
---	--	---	---

[sign - three]

Page 10

sign 47:21 signal 38:17 signature 47:4 signed 47:23 61:17 significantly 36:18 signify 33:10 signing 69:14 simply 43:4 sit 5:23 7:19 8:1 24:1 29:21,22 30:10 31:5 32:6 33:22 44:20 65:9 sitting 30:4 situation 42:18 situations 49:16 six 37:25 39:16 40:16 42:13 66:4 skips 29:1 slight 14:5 slow 29:16 slowly 40:5 small 57:23 social 17:21 24:11 30:20 58:22 software 57:25 59:25 solemnly 3:14 somebody 15:15 34:24 35:6 42:6 58:15 59:5 something's 64:14 somewhat 40:14 son 36:24 soon 63:17 sooner 33:21 42:17 sore 27:20 sorry 13:4 sort 14:1 24:5 26:15 28:10 32:6 33:14 60:8,9 67:22 south 1:18 specialists 4:23 5:1 specialty 4:5,8 specific 7:20 24:16 33:2 37:8 40:22	43:21 specifically 44:21 specifics 32:14 specified 69:13 spell 3:20 spend 35:7,21 spinal 6:4 14:13 43:3 64:18 spine 2:6 4:14,21 14:14 15:13,20 28:18 43:5 spoken 7:3 ss 69:2 stabilize 38:16 stable 42:11 stand 58:10 standing 29:3,17 30:11 standpoint 41:4 start 36:20 started 64:20 starting 27:22 starts 28:2 state 3:20 63:17 69:2,5 stated 48:25 statement 2:8 23:8 23:12 26:9 states 1:1 60:1,1 station 26:15 status 58:23,23 stenosis 14:13 43:3 stereotype 3:8 stiff 27:20 28:8 29:16 stiffness 32:17 stimulator 6:4 64:18 stipulated 3:2 stipulations 69:14 story 60:25 street 1:13,18,21 strife 65:2 strike 13:8 42:20 studies 45:4,6	study 10:5 subjective 16:15 submitted 48:1 substance 40:6 success 34:7 suffering 15:19 46:6 suggest 12:6 28:16 45:7,10 suggested 43:21 suggests 28:14 suit 69:21 suite 1:13,18,21 3:24 summer 54:21 supplemental 2:8 supposed 38:16 40:5 58:20 supposedly 51:11 sure 10:9 13:11 26:9 31:9,9 41:10 45:6 45:12 55:3 surgeries 48:14 surgery 21:16 22:10 41:19 surgical 41:3 surprise 61:16 swelling 32:17 sworn 3:14 69:7 symptomatic 55:8 symptoms 29:24	teeth 32:19 tell 6:1 10:6 15:6 29:10 30:15 telling 23:17 43:14 58:15 tend 22:3 28:6 30:3 38:25,25 39:2 51:13 tends 24:6 31:5 term 60:4 terminated 50:11 terms 8:13 31:18 58:22 64:21,24 territory 57:5 test 52:23 testified 3:15 49:8 testify 69:7 testimony 43:25 63:10 69:22 testing 26:2 tests 55:5 thank 46:12,14 61:10 66:17,19,21 66:22 68:6 therapy 21:21 22:11 thing 7:22 23:16,25 25:18 26:5,13,14,16 27:21 28:11 32:7 33:11,14 34:14 41:1 51:13 64:7 66:2 things 21:3 27:3 34:17 35:23 38:10 42:15 43:4 52:9 think 4:19 6:18 7:16 10:23 13:13 16:15 19:22 20:6 25:22 28:24 46:9 47:7 51:4 53:2,13 59:20 62:14 63:19 thinks 19:3 third 16:15 thought 61:15 64:18 three 21:22,22 31:11 36:14 40:15 41:24 42:10 65:17,18 67:8 68:7
		t	
		t 3:1,1 69:1,1 tablets 39:16 take 18:6 28:22 43:7 43:25 taken 1:5 5:13 12:8 59:8 67:16 69:12,18 talk 17:20 18:11 21:3 60:16 talked 45:17 talking 34:14 53:16 67:9 talks 27:20	

[time - wrote]

Page 11

time 1:12 3:9 12:7 16:9 17:17 18:6 21:10 24:2,17,22 26:11 27:5 28:4 33:25 34:13 35:8,22 36:9 37:11,23 48:6 61:16 63:15,16 64:2 69:12 times 7:10 21:4,22 21:22,22 22:2 30:18 32:7 33:17 42:10 61:22 today 5:23 7:19 8:2 30:21 44:20 60:22 65:10 68:3 told 18:2 23:12 46:9 61:24 62:1,14 top 51:6 track 55:2 tracking 60:10 tramadol 32:16 37:25 38:3,4 39:15 42:15 transcription 3:8 treated 6:12 7:13 treating 21:11 22:10 52:2 54:9 56:3,7,24 57:5 treatment 6:8 54:11 56:12,22 trial 3:10 43:17 true 23:16 69:16 truth 69:8,8,9 try 31:19 34:5 39:5 39:18 50:1,3 57:17 61:7 trying 13:9 36:23,25 38:24 57:9 tv 35:5 twice 61:19 two 5:1 66:5 67:7 type 21:4 49:10,11 49:15,15,25 50:5 57:3	types 8:12 49:18 50:3 51:20 typical 51:17 typically 6:20 8:10 8:23 49:17 typo 59:20 typos 58:3	v v 3:22 vague 32:9 valid 12:7,7,11 46:10 63:10 64:10 validity 65:6 valuable 42:17 van 1:13 3:24 variety 14:11 vas 29:9 32:1 virtually 61:23 visit 2:10 20:2,7,10 22:13 24:25 25:18 27:9 31:13 35:11 36:15 41:23 42:2 53:13 55:13 60:15 62:2 visits 40:22 42:13 64:23 visual 30:18 vitamin 33:14 voc 8:7 vs 1:5	61:3 65:15 week 11:8,11 12:3 went 48:10 57:11 whatnot 46:20 56:10 whereof 69:22 william 1:17 wishes 21:8 witness 2:2 3:7 46:14 66:19,22,25 67:3,6,10 68:11 word 45:19 words 33:3 62:6,7 work 7:24 8:11,13 9:22 17:23 18:10,22 19:11 20:13 22:24 23:10,20,22 24:5,5 24:11,19 27:7 33:21 34:5 35:22 44:15 46:19 47:14 48:19 48:21,21 49:1,3,5 49:15,15 50:19,23 51:2,24,25 53:3 58:12,17,23 62:4,21 worker 49:22 workers 7:21 working 19:10 27:7 48:5 works 15:23 17:25 38:5,14 40:4 52:12 58:13 workwell 9:8 12:1 63:11 world 58:4 worse 32:15 worsened 54:22 worst 23:24 30:21 worth 34:19 write 29:15 30:4,6 writes 32:15 writing 19:13 69:10 written 13:10 22:1 wrong 35:19 wrote 32:19
	u u 3:1 uh 13:24 16:14 17:9 27:17 44:13 52:1 59:23 unable 18:21 unchanged 17:13 25:19 uncommon 27:23 undergo 26:1,19 undergone 48:15 understand 30:6 35:18 39:22 40:20 41:9 52:11,11 65:9 65:12 66:15 understanding 13:1 14:18 15:11 19:9,20 24:4 49:1 52:7,25 67:21 understood 7:25 unfortunately 58:6 59:21 united 1:1 unsure 23:19 unusual 37:1 54:7 57:3 update 59:25 updated 18:9 use 30:24 31:21,25 32:16 37:21 38:21 38:22 40:7 42:15 51:13 54:10 usually 15:21 18:15 21:2 23:4,7 34:19 34:24	w wait 13:5 waive 68:9,11 waived 3:5,6,8 69:15 walk 64:11 walking 25:5 29:21 32:10 want 21:3 33:12 40:6 55:23 58:24 60:16,19,22,24 61:8 64:17 wanting 64:25 warrant 65:4 watch 31:24 watching 35:5 water 36:20 way 5:10 18:18 23:7 26:21 30:17,24 38:16 39:2 40:4 45:11 51:21 60:10	

[x - ymca]

Page 12

x
x 2:1 31:2
y
y 36:24 37:3
yeah 19:1 22:8
27:14 36:11 44:2
58:1 66:25 67:3,6
year 42:12
years 66:5
ymca 36:7

Page 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

DAVID BLISS,) CASE NO. 4:12-CV3019
)
PLAINTIFF,) DEPOSITION OF
) MICHAEL H. MCGUIRE, M.D.
VS.)
) TAKEN ON BEHALF OF
BNSF RAILWAY COMPANY,) PLAINTIFF
)
DEFENDANT.)

VIDEOTAPED DEPOSITION OF MICHAEL H.
MCGUIRE, M.D., taken before Gretchen Thomas,
Certified Court Reporter, Registered Professional
Reporter, Certified Realtime Reporter, General
Notary Public within and for the State of Nebraska,
beginning at 12:41 p.m., on June 18, 2013, at the
Professional Offices of Thomas & Thomas Court
Reporters, 1321 Jones Street, Omaha, Nebraska 68108,
pursuant to the Federal Rules of Civil Procedure.

Page 2

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Page 3

INDEX

1	CASE CAPTION	Page 1
2	APPEARANCES	Page 2
3	INDEX	Page 3
4	TESTIMONY	Page 4
5	REPORTER CERTIFICATE	Page 60
6	DIRECT EXAMINATION: By Mr. McMahon	Page 4
7	CROSS-EXAMINATION: By Mr. Sattler	Page 31
8	EXHIBITS:	
9	80. CURRICULUM VITAE MARKED OFFERED	4
10	81. MEDICAL RECORDS MARKED OFFERED	4
11	82. COLOR PHOTOGRAPHS MARKED OFFERED	35

Page 4

1 (Whereupon, the following proceedings were
2 had, to-wit:)
3 (Exhibit Nos. 80-81
4 marked for identification.)
5 VIDEOGRAPHER: Please stand by.
6 Counsel, we are on the record.
7 This is Tape No. 1 to the Videotape
8 Deposition of Michael McGuire, M.D., in a deposition
9 taken by the plaintiff in a case entitled David
10 Bliss versus BNSF Railway Company; Case No.
11 4:12-CV-3019.
12 This deposition is being held at the
13 offices of Thomas & Thomas Court Reporters,
14 1321 Jones Street in Omaha, Nebraska.
15 Today's date is June 18th, 2013. The
16 approximate time is 12:41 p.m.
17 My name is John Thomas, Videotape
18 Specialist, from the office of Thomas and Thomas.
19 Our court reporter this afternoon is
20 Gretchen Thomas.
21 Will counsel please identify themselves
22 for the record.
23 MR. MCMAHON: William J. McMahon for
24 the plaintiff, Mr. Bliss.
25 MR. SATTLER: Tom Sattler, BNSF

Page 5

1 Railway Company.

2 MICHAEL H. MCGUIRE, M.D.

3 having been first duly sworn,
4 was examined and testified as follows:

5 DIRECT EXAMINATION

6 BY MR. MCMAHON:

7 Q. Good afternoon, Doctor.

8 A. Good afternoon.

9 Q. Could you please state your name for the
10 members of the jury.

11 A. My name is Michael H. McGuire, M.D.

12 Q. And do you have a profession or occupation
13 that you specialize in?

14 A. Yes. I'm an orthopedic surgeon.

15 Q. And what does it mean to be an "orthopedic
16 surgeon"?

17 A. Orthopedic surgery is defined as the
18 medical specialty that provides evaluation and
19 treatment for conditions of the spine and
20 extremities. Generally speaking, we're the bone and
21 joint doctors.

22 Q. Okay. And could you tell the jury a
23 little bit about your education and training to be
24 an orthopedic surgeon.

25 A. Yes. I attended Creighton University here

Page 7

1 full-time employee of that hospital for many years,
2 about 25 years. I have headed the orthopedic
3 service at the Creighton University Hospital here in
4 Omaha, and I continue to hold privileges at
5 Creighton.

6 Q. Okay. And are you board certified in that
7 field?

8 A. Yes, I am. I'm certified by the American
9 Board of Orthopedic Surgery.

10 Q. What does that mean, to be "board
11 certified"?

12 A. It means that you've met the educational
13 and training requirements as we just discussed.
14 You've successfully mastered the fund of knowledge
15 necessary to practice orthopedic surgery and have
16 passed a written test for that. And then finally,
17 you've demonstrated your abilities in the practice
18 of orthopedic surgery, both by a review of your
19 practice and by an oral examination of, um -- of
20 that practice. If you meet all those things, you
21 are granted certification by the American Board of
22 Orthopedic Surgery.

23 Q. And I take it over the past -- over three
24 decades of -- in your career, you've treated other
25 patients with similar back conditions as Mr. Bliss?

Page 6

1 in Omaha, and earned a bachelor of science in
2 chemistry degree in 1971 -- May of 1971.

3 I continued at Creighton for my medical
4 degree and earned an M.D. in May of 1975. I then
5 served a five-year orthopedic surgery residency at
6 St. Louis University in St. Louis, and completed
7 that residency in -- on June 30th, 1980.

8 Q. And could you tell the jury a little bit
9 about the current nature of your practice; what type
10 of patients you see, what type of conditions you
11 treat.

12 A. I'm a -- I practice as an orthopedic
13 surgeon in Columbus, Nebraska, a town of 22,000
14 people about 90 miles from here. I practice a
15 general orthopedic surgery with two other surgeons.

16 I do a number of joint replacements, do a
17 number of fracture work. And my interest for many
18 years in orthopedics -- or my special interest has
19 been tumors of the musculoskeletal system, so I
20 continue to see a number of patients referred for my
21 treatment.

22 Q. And have you been on the staff of any
23 hospitals, whether here in Omaha or Columbus?

24 A. Yes, I have. I'm currently -- I practice
25 at the Columbus Community Hospital -- actually as a

Page 8

1 A. That is true.

2 Q. And have you performed back surgeries on
3 those types of patients?

4 A. In a very limited fashion.

5 My practice of orthopedics does not
6 include routine discectomies or spinal fusions, but
7 on the occasion when tumors have affected the spine,
8 then I've worked with spine surgeons, either
9 orthopedists or neurosurgeons, to do that type of
10 surgery.

11 Q. Okay. And in the field of orthopedics, do
12 you have to do continuing medical education courses
13 to keep up with the certification in the field?

14 A. Yes.

15 Q. Okay. And do you regularly do that type
16 of continuing education and attend conferences in
17 the field?

18 A. Yes. Actually, the orthopedic community
19 has developed a -- a whole range of opportunities
20 for that, and I participate for a number of reasons,
21 including the fact that in the state of Nebraska, we
22 must demonstrate some level of continuing medical
23 education to maintain our license.

24 Q. Okay. Doctor, at my request, did you
25 perform a medical records review, as well as a -- an

Page 9

1 examination of Mr. David Bliss?

2 A. Yes, I did.

3 Q. And, um, have you done this type of review
4 before?

5 A. Yes, I have.

6 Q. Is it possible to estimate how many times,
7 either per year or a period of time, that you
8 perform this kind of medical/legal consultation?

9 A. Um, specific to a case like yours, it
10 would be a handful of times per year. For many
11 years, I -- I've done, um, similar work, perhaps 30
12 or 40 or 50 patients evaluated per year.

13 Q. Okay. And when you did this review, what
14 materials did you review in helping you to formulate
15 your opinions and conclusions in this matter?

16 A. Can I --

17 Q. Sure.

18 A. You or your office was good enough to send
19 me this box of records. I haven't weighed it, but
20 it's this box of records (indicating).

21 Q. Okay. And are those the medical records
22 for Mr. Bliss?

23 A. Yes, they are.

24 Q. Both the medical records that exist after
25 the February 2011 reported work-related injury, as

Page 10

1 well as -- that predate that?

2 A. Yes, I believe that's true. I'd have to
3 look -- on the predated ones, I'd have to look
4 through. But yes, there's a complete set of records
5 there.

6 Q. And you also had a chance to do a physical
7 examination upon Mr. Bliss?

8 A. That is correct.

9 Q. And do you remember the date of that?

10 A. I saw Mr. Bliss on the 31st of May, 2012.

11 Q. All right. And is a review of these types
12 of documents and -- as well as a physical
13 examination of the patient, is that the type of
14 information and documentation that you and other
15 physicians and orthopedic surgeons typically rely
16 upon to assist them in formulating opinions and
17 conclusions as to the cause of a current medical
18 condition of a person?

19 A. Yes.

20 Q. Okay. And, in fact, did you rely upon
21 these medical records in your own review --
22 examination of Mr. Bliss in formulating your own
23 opinions and conclusions in this matter?

24 A. Yes, I did.

25 Q. Before we get to those, what findings --

Page 11

1 pertinent findings did you gather from your review
2 of the medical records of Mr. Bliss's orthopedic
3 history?

4 A. Well, in my report to you, I attached from
5 that box of records a small collection of medical
6 records that I found to be most pertinent to the
7 case of Mr. Bliss. I can list those, if you'd like
8 me to.

9 Q. If you could, yeah.

10 A. I hope to do this in the correct order.

11 So the first would be an office note, a
12 note of the evaluation by Anthony Cox, PA-Certified,
13 dated 4 February 2011, in reference to David Bliss.

14 So this would have been his office
15 evaluation the day -- the day after the injury.

16 Q. Okay.

17 A. So that would be the first one.

18 Then there is a report of -- of MR imaging
19 of Mr. David Bliss's lumbar spine, and the MR images
20 were obtained on the 18th of March, 2011, so about
21 six weeks later.

22 And the next is the -- the report of the
23 operation -- the operative report of -- of surgery
24 performed by Daniel Noble for the patient David
25 Bliss, and that's dated 6 April 2011.

Page 12

1 And then -- and then there -- and then
2 there's a set of records for further evaluation of
3 Mr. Bliss, and these records are authored by Keith
4 Lodhia, L-O-D-H-I-A, M.D., of Midwest Neurosurgery
5 and Spine Specialists, 8 June 2011, to September
6 2011, and 7 November 2011.

7 And then finally again attached to my
8 report for you is a report of Mr. Bliss's operation
9 by Daniel Noble, a lumbar spine operation, from the
10 6th of May, 2010, so prior to his injury.

11 And a report from the Lincoln Physical
12 Therapy Associates date 3 October 2008 in the form
13 of a letter to Dr. David Clare, C-L-A-R-E.

14 And finally the report of Mr. Bliss from
15 the Spine and Pain Center of Nebraska from
16 21 December 2011. And this is authored by Dr. Liane
17 Donovan.

18 Q. Thank you, Doctor.

19 Before we move on, maybe if we could
20 define a few medical terms that might be helpful
21 before we move on.

22 Doctor, what does the term radiculopathy
23 mean?

24 A. In medical terms, it -- it refers to the
25 way pain travels or radiates out through an

Page 13

1 extremity.

2 So as an example, if one has a herniated
3 disc in their low back, that disc may push against
4 the -- a nerve root as it leaves the spine, and that
5 nerve travels entirely down the extremity. Low
6 back, it travels down the lower extremity, of
7 course. And from neck, it travels through the upper
8 extremity.

9 So we make reference to a radiculopathy,
10 we're really referring to pain radiating out or
11 traveling out through the length of an extremity.

12 Q. Okay. And what difference is there, if
13 any, between the term disc extrusion and herniated
14 disc?

15 A. Probably no -- no difference.

16 A disc extrusion may be a little bit more
17 dramatic thing, that the disc -- a portion of the
18 disc was actually squirted out. But -- but I think
19 for purposes of this discussion, a herniation or
20 extrusion of the disc would be the same.

21 Q. All right. And the medical procedure
22 discectomy, what's that?

23 A. It's an operation, a form of surgery, and
24 the goal is to remove the herniated or extruded
25 portion of the disc and, therefore, take pressure

Page 15

1 discectomy helps patients that have a disc
2 extrusion?

3 A. Yeah. Well, it's simply by taking the
4 pressure off the nerve root. So if you were to
5 think about -- if my arm was to be the nerve root --
6 obviously much bigger than a true nerve root -- and
7 a disc was pushing against it, any of us could stand
8 that for a while, but after some length of time,
9 we'd want the disc to be removed. So it's to take
10 pressure off the nerve root or to remove the
11 offending cause of the pinched nerve root.

12 Q. And, um, how is it that a fiset rhizotomy
13 is used after a micro discectomy for patients that
14 still have pain?

15 A. Well, I think the key phrase there in your
16 question -- who still have pain.

17 So if a patient -- if a patient has
18 undergone surgery to remove a herniated disc, and
19 hopefully the pain that is radiating through their
20 extremity, hopefully that's gone, but if they still
21 have back pain, then a rhizotomy would be a
22 reasonable attempt to relieve that part of the
23 condition.

24 Q. Okay. And another term, what's a spinal
25 cord stimulator?

Page 14

1 off the nerve root where it's being pinched.

2 Q. And another medical procedure,
3 rhizotomy -- a fiset rhizotomy?

4 A. Yes.

5 Q. What's that?

6 A. Hard to know.

7 The spine -- we commonly think of the
8 spine as a series of blocks; and, in fact, it is a
9 series of blocks, separated in each way between a
10 cushioning disc.

11 But, in fact, if we reach to -- any of
12 us -- and feel our spine, feel our back, we're not
13 feeling those blocks, but we're feeling the roof,
14 um, of the spine that protects the spinal cord and
15 the nerve roots. And there are joints back there to
16 allow the spine to move and move.

17 And people are -- certainly a potential
18 cause of back pain is wearing out those joints, much
19 like an arthritis or something. And so one can
20 destroy the nerves that supply those little joints
21 and perhaps no pain would come from there. And
22 that -- the procedure to destroy the nerves
23 surrounding these little joints where the back of
24 the spine hooks together is known as a rhizotomy.

25 Q. Okay. And then how is it that a

Page 16

1 A. Um, the -- it's an implantable device that
2 discharges a -- small electric shocks, and I think
3 the best way to probably think about is to perhaps
4 confuse or -- confuse the brain or the pain
5 receptors, and -- if you were to tap-tap-tap-tap-
6 tap-tap-tap for -- forever on something, maybe
7 finally you just kind of wear out its ability to
8 recognize pain. So it's a device, again, hope to
9 relieve pain.

10 Q. All right. And then finally the last term
11 that you use in your report is "failed back
12 syndrome."

13 A. Yes.

14 Q. What is meant by that term?

15 A. It's kind of a catch-all I suppose, but
16 Mr. Bliss here is a patient who's had -- I think at
17 least three operations on his spine, and a number of
18 other procedures. And despite everyone's best
19 attempts, and despite appropriate indications for
20 surgery, and despite time and everything else, the
21 fact of the matter is he remains, um -- he continues
22 to suffer back pain.

23 And so if you've kind of used up all of
24 your reasonable choices and you still have pain, you
25 gather that all together into one phrase, "failed

Page 17

1 back syndrome."

2 Q. Okay. You were able to have a physical
3 examination of Mr. Bliss; is that right?

4 A. Yes, I did.

5 Q. What were your findings on your physical
6 examination?

7 A. I report those findings on the first
8 paragraph of Page 3 of my letter to you, and for
9 completeness sake, my letter's dated 31 May 2012.

10 I will read this short paragraph.

11 (Reading):

12 On exam, I noted a pleasant, healthy
13 appearing male who moved about the office in a
14 satisfactory fashion. The first step or two after
15 arising from a seated position in our waiting room
16 chair caused pain. He then ambulates for short
17 distances in a normal fashion. Mr. Bliss was able
18 to partially disrobe for the exam without
19 difficulty. Visual examination of his lumbosacral
20 spine is remarkable for healed surgical incisions
21 consistent with his history. I noted a pain free,
22 passive, full range of motion of both hips and
23 knees. Mr. Bliss has bilateral pes planovalgus
24 (flatfeet) deformities. The deep tendon reflexes
25 were measured at the knee jerk and ankle jerk level.

Page 18

1 On the right lower extremity, the reflexes were
2 noted to be 2+/4 with provocation. On the left
3 lower extremity, the reflexes were absent and could
4 not be elicited, even with provocation. The
5 function of the extensor hallucis longus muscle and
6 tendon to each great toe is intact, brisk, and
7 strong. His distal pulses at the posterior tibialis
8 and dorsalis pedis levels are easily palpable
9 bilaterally.

10 And then I add that Mr. Bliss is a
11 nonsmoker.

12 Q. And then the following paragraph, you
13 summarize some of your opinions in this matter; is
14 that right?

15 A. Yes, I do.

16 Q. And is that based upon both the review of
17 the medical records and documents that you had in
18 this case, as well as your examination of Mr. Bliss?

19 A. And the history that I took from Mr. Bliss
20 on that day. So that -- the records, the patient's
21 history, and my physical examination, yeah.

22 Q. And what was that history that he provided
23 to you on that day?

24 A. If we go back to Page 1, the second
25 paragraph -- and I will again read.

Page 19

1 (Reading):

2 Mr. David R. Bliss is a now 56-year-old
3 male who has been an employee of the BNSF Railroad
4 for the past 22 years. Mr. Bliss reports the onset
5 of low back pain with radicular symptoms (especially
6 through the left lower extremity) while on the job
7 on 3 February 2011. Mr. Bliss was repairing the
8 dented wall and bent door frame of a boxcar at that
9 time. The project required the use of a hydraulic
10 ram that, once maneuvered into place, can be used to
11 jack the walls apart. This returns the frame of the
12 door and wall of the boxcar to the original
13 position. I reviewed photos of the device and how
14 it works. The ram is estimated to weigh at least
15 150 pounds. Mr. Bliss reports that at the moment of
16 the onset of the pain, he was not actually lifting
17 any objects. Simply as he stood up, something
18 popped in his low back. And the episode occurred
19 following a two- or three-hour period of repeatedly
20 maneuvering the ram into place and using that ram to
21 repair the boxcar.

22 Q. And in the course of medical treatment
23 that Mr. Bliss received after this incident on
24 February 3rd, 2011, could you summarize that for the
25 Ladies and Gentlemen of the Jury.

Page 20

1 A. Yes. And this makes reference to the
2 pertinent medical records that we already reviewed.
3 But to summarize it, because of the severity of the
4 symptoms, Mr. Bliss reported the event to his
5 superiors at BNSF that day. He then sought
6 evaluation on 4 February 2011 by Anthony Cox, PA-C.
7 MR imaging of the lumbar spine was completed on 18
8 March 2011. Mr. Bliss underwent lumbar spine
9 surgery on 6 April 2011. Unfortunately, his
10 post-operative report has been unsatisfactory. He
11 has been unable to return to work. Fasic
12 rhizotomies were performed by James Devney, D.O., in
13 October of 2011.

14 Q. Did you also gather from your review of
15 the records, as well as your discussions with
16 Mr. Bliss, his previous surgical history, previous
17 to February 3rd, 2011?

18 A. Yes, I did.

19 Q. Could you summarize that for the jury as
20 well?

21 A. I can do so in an expert fashion.

22 The next paragraph of my letter,
23 Mr. Bliss's past surgical history is significant.
24 He initially underwent a lumbar discectomy in 2003.
25 He then underwent a lumber discectomy (at a more

Page 21

1 proximal level) on 6 May 2010. Following that
2 procedure, he was in an off-work status for
3 approximately four months. He reports that he
4 successfully returned to work in October of 2010.
5 Mr. Bliss did well and apparently was working
6 without restrictions until the morning of three --
7 until the morning of 3 February 2011. As noted
8 above, he has not worked since that time.

9 Q. What -- what's your understanding of the
10 surgery that Mr. Bliss had on the 6th of May, 2010?

11 A. As I understand the history from the
12 records sent by Mr. Bliss's report, I state that as
13 noted -- or excuse me. Strike --

14 I put down that the 6 May 2010 surgery was
15 not the result of an injury at work. Rather,
16 Mr. Bliss's back went out while lifting a bucket of
17 water for his dog.

18 Q. And what type of surgery was that
19 performed by Dr. Noble?

20 A. That was a lumbar discectomy, and we have
21 a copy of the operative report from that date in
22 these records.

23 Q. Okay. And what was the procedure after
24 the work-related injury of February 3rd, 2011,
25 that -- the surgical procedure that Dr. Noble

Page 22

1 performed on Mr. Bliss on April 6, 2011?

2 A. I'll read from the operative report of
3 that date, 6 April 2011.

4 The operation is listed as a left L3-4
5 micro discectomy, re-exploration. And No. 2, use of
6 an operative microscope.

7 And the reason that it's listed as a
8 re-exploration is because the 6 May 2010 discectomy
9 had been at the same level, the left side of the
10 Lumbar 3-Lumbar 4 disc.

11 Q. Okay. And what does it mean to be a
12 recurrent left L3-4 disc extrusion?

13 A. Well, what it means is that Dr. Noble
14 believes -- and certainly the history suggests
15 that -- that the first time that the L3-4 disc
16 extruded or pinched out against the nerve and the
17 extruded portion -- the offending portion was
18 removed and the patient got better, but now an
19 additional extrusion, more of the disc has come out
20 of the space and is pinching the nerve. You know,
21 when we do a discectomy, we perhaps take -- most
22 half of the disc out, which leaves people at some
23 risk for recurrence or -- and Dr. Noble's listing
24 here suggests that he believes that there was a -- a
25 recurrence of that disc extrusion at that level.

Page 23

1 And for that reason, required additional discectomy
2 through a re-exploration of that same level.

3 Q. And when you say, "that level," could you
4 indicate where on a person's spine is this -- the
5 re-excision -- re-extrusion of the disc?

6 A. Sure.

7 So all of us -- or most of us, almost all
8 of us, have 12 thoracic vertebrae or the blocks, and
9 those are the vertebrae that our ribs are hooked to,
10 And then almost all of us have five low back or
11 lumbar vertebrae or blocks. And then finally we
12 have the sacrum or the tailbone. So at the 3-4
13 disc, it would be halfway down the lumbar spine.

14 Q. And then on your examination -- I think it
15 was continued on Page 3 of your report -- did
16 Mr. Bliss present to you with any symptoms on that
17 particular day?

18 A. Yes. If we go to the --

19 Q. Page 2, maybe?

20 A. Yeah. If we go to the bottom paragraph of
21 Page 2 of my 31 May 2012 report.

22 (Reading):

23 At the time of my evaluation, Mr. David R.
24 Bliss reported constant left lower extremity pain
25 that radiates to his heel and is associated with

Page 24

1 numbness over the lateral aspect of his left foot.

2 Q. And his current treatment at that time was
3 what?

4 A. He was in a pain management program
5 directed by -- by Dr. Donovan.

6 Q. And did he indicate what activities, if
7 any, increased his level of pain?

8 A. He reports that he is relatively
9 comfortable while seated or lying down. He has
10 learned to stand and to bend in a slow and careful
11 fashion. Prolonged standing and walking caused his
12 lower extremity symptoms to increase.

13 Q. Okay. And Doctor, based upon your review
14 of the medical records, and also your physical
15 examination of Mr. Bliss, did you have an opinion,
16 to a reasonable degree of orthopedic certainty, what
17 the cause of the constant left lower extremity pain
18 that radiated into Mr. Bliss's heel and associated
19 numbness over the lateral aspect of his left foot,
20 what that was caused from?

21 MR. SATTler: I'll object to the form
22 of the question as it relates to a history provided
23 by the patient and not his physical exam. **Overruled**
24 BY MR. MCMAHON:

25 Q. Just based upon your physical exam and the

Page 25

1 review of the records in this case, and background
2 and training as an orthopedic surgeon, do you have
3 an opinion as to what was causing the lower
4 extremity radiating pain in Mr. Bliss as reported?

5 A. Yes, I do.

6 Q. And what is that?

7 A. I think I best tried to provide that by
8 the statement that I would characterize his current
9 status as a failed back syndrome. And certainly his
10 reports of pain radiating to the heel of his foot
11 and my findings suggest that there's ongoing
12 irritation or pinching of some or one of the nerve
13 roots exiting the lumbar sacral spine.

14 Q. Okay. And based upon your physical exam,
15 your review of the records, as well as your
16 examination of Mr. Bliss, did you formulate an
17 opinion, to a reasonable degree of orthopedic
18 certainty, whether Mr. Bliss had reached a point of
19 maximum medical improvement as of May 31st, 2012?

20 A. Yes, I did. And I believe that Mr. Bliss
21 had reached a point of maximum medical improvement
22 effective the date of my examination, 31 May 2012.

23 Q. And based upon that opinion, did you
24 formulate any restriction -- medical restrictions
25 that you believe were appropriate for Mr. Bliss?

Page 26

1 MR. SATTLE: Well, I'll object to
2 the form of the question. Also, it goes beyond the
3 disclosure made by the May 31, 2012, report. There
4 is no such opinion or testimony.

5 MR. MCMAHON: Very good. I'll
6 withdraw that, Mr. Sattler, and I'll rephrase it.

7 MR. SATTLE: I should have looked at
8 your face, Doctor.

9 THE WITNESS: Oh, boy, they got me
10 now. That's off...

11 MR. MCMAHON: I'll rephrase it.
12 BY MR. MCMAHON:

13 Q. Doctor, based upon your opinion that
14 Mr. Bliss had reached maximum medical improvement,
15 effective May 31, 2012, did you come to any opinion
16 whether Mr. Bliss had reached any -- whether
17 permanent or -- or impairment level of function,
18 based upon your review of the records, your
19 examination of Mr. Bliss, and your education and
20 training and experience in orthopedic surgery?

21 MR. SATTLE: Hang on a second,
22 Doctor.

23 I'll object to the form of the question.

24 If the question is did you rate him under
25 the AMA guides to the evaluation of permanent

Page 27

1 impairment, do you have an opinion in that regard, I
2 don't have an objection to that. If that's what the
3 doctor is going to address, that's fine.

4 MR. MCMAHON: Okay.

5 BY MR. MCMAHON:

6 Q. Doctor, I'll withdraw that previous
7 question. Okay, Tom?

8 Doctor, did you rate Mr. Bliss based upon
9 your review of the medical records, your examination
10 of Mr. Bliss, as of May 31st, 2012?

11 A. Yes, I did.

12 Q. And what does that mean, first of all?

13 A. Um, well, based on everything that we've
14 been discussing, and in these situations, the
15 physician is asked to provide a rating of a
16 permanent partial impairment of function. And to
17 assist us in that task, the AMA has provided a
18 text -- a large text that is named the AMA Guides to
19 the Evaluation of Permanent Impairment.

20 At this time, I used the Fifth Edition of
21 that textbook.

22 And in Table 15-3 of that text, the table
23 provides criteria for rating impairment due to
24 lumbar spine injury. And I am of the opinion that
25 Mr. Bliss and his condition is best described in the

Page 28

1 DRE lumbar category III. And for that reason, I
2 would apply a 12 percent impairment of the whole
3 person.

4 Q. And that phrase, "12 percent impairment of
5 the whole person," it -- is it possible for you to
6 translate that from orthopedic terminology to maybe
7 what us laypeople might understand?

8 A. Well, I guess -- I hope this is
9 appropriate, but I -- I often point out to patients
10 that this is not a -- some sort of rating of
11 disability.

12 If -- and I use myself as an example. I
13 happen to be a surgeon, so if I were to for some
14 reason suffer an amputation of my foot or lower leg,
15 I could be rated, according to a table in the
16 guides.

17 In fact, it would really not disable me in
18 any way according to my profession. Other people,
19 it would be more disabling.

20 So really I guess what this means is that
21 12 percent of all the things that we think a regular
22 person like Mr. Bliss can do, he can no longer do.
23 So he's lost -- or he's suffered a significant
24 impairment of the normal function that we would
25 expect of a 56-year-old man.

Page 29

1 Q. All right. And then based upon that, did
2 you come to any conclusions of whether Mr. Bliss
3 could return to his prior position with the railroad
4 as railroad carman?

5 MR. SATTTLER: I'll object to the form
6 of the question as no proper and sufficient
7 foundation.

8 BY MR. MCMAHON:

Overruled

9 Q. Okay.

10 A. At the completion of -- at the completion
11 of my letter, I offer the opinion, finally, I find
12 it unlikely that Mr. Bliss can or will return to the
13 duties required of his previous position at the
14 BNSF Railroad.

15 MR. SATTTLER: And again, I'll move to
16 strike: Without sufficient foundation.

Overruled

17 BY MR. MCMAHON:

18 Q. Okay. And Doctor, what's the basis for
19 your opinion regarding that he will not return to
20 his previous position with the railroad?

21 A. Um, he -- it's my understanding that he
22 did hard physical labor, such as jacking apart
23 railroad cars to repair them. And his combination
24 of clinical problems, as I've said, summarized as a
25 failed back syndrome, make it particularly painful

Page 30

1 for him to do heavy labor.

2 Q. All right. And lastly, Doctor, do you
3 have an opinion, to a reasonable degree of medical
4 certainty, as to whether the reported February 3rd,
5 2011, work incident was a cause in whole or in part
6 to the -- to the injury to Mr. Bliss's spine and the
7 subsequent medical treatment?

8 A. Yes, I do.

9 Q. And the basis for that opinion?

10 A. My -- the -- all the things that we've
11 covered in this letter.

12 Q. Okay. And I guess I should close the loop
13 there.

14 So you believe it was connected, to a
15 reasonable degree of medical certainty, to the
16 February 3rd, 2011, work injury?

17 A. Yes.

18 MR. SATTTLER: Hang on a second
19 Doctor.

20 I'll object: No proper, sufficient
21 foundation. Also object to the form of the
22 question.

Overruled

23 BY MR. MCMAHON:

24 Q. Okay.

25 A. I believe that the 3 February 2011 injury

Page 31

1 is the cause of the treatment and outcome as we've
2 described -- or reported in my letter.

3 Q. Okay. And the basis for that, again?
4 Sorry.

5 A. The patient's history, my review of his
6 medical records, and my findings at physical
7 examination.

8 MR. SATTTLER: Same objection. Move
9 to strike.

Overruled

10 MR. MCMAHON: Thank you, Doctor.
11 That's all.

CROSS-EXAMINATION

12 BY MR. SATTTLER:

13 Q. Now, Dr. McGuire, you saw the patient,
14 Mr. Bliss, at the request of his lawyer; is that
15 right?

16 A. That is true.

17 Q. It was not a referral for another
18 health-care provider?

19 A. That is correct.

20 Q. And it was not intended for purposes of
21 examining Mr. Bliss as a patient for treatment?

22 A. That is correct.

23 Q. And in other words, this was a specific
24 arrangement made so that you could offer opinions,
25

Page 32

1 not unlike those that have just been provided by you
2 in direct examination?

3 A. That is correct.

4 Q. Now, did this examination occur at your
5 office, then?

6 A. Yes, it did.

7 Q. In Columbus?

8 A. Yes.

9 Q. Correct.

10 And this would have been on May 31st of
11 2012?

12 A. Correct.

13 Q. This would have been roughly 16 months
14 after the incident alleged to have occurred on
15 February 3rd of 2011, right?

16 A. Correct.

17 Q. In terms of the actual time that you would
18 have spent with Mr. Bliss, how much time would that
19 have taken?

20 A. With Mr. Bliss, about 30 minutes.

21 Q. In terms of the physical exam of
22 Mr. Bliss, how much time was spent in the physical
23 exam part? I'm talking about the clinical exam
24 where you've got him in the room and you're looking
25 at him.

Page 33

1 A. Well, we were in a room -- the two of us
2 in an exam room for those 30 minutes. The actual
3 touching, checking, doing reflexes would be 5 or 7
4 or 8 minutes of that.

5 Q. And in terms of the records review in
6 preparing your report, approximately how much time
7 was involved there?

8 A. Um, probably 3 hours.

9 Q. Have you billed counsel for plaintiff in
10 this case yet?

11 A. Yes, I have.

12 Q. And what amount was that?

13 A. Today, there's a bill for \$1800 for this
14 deposition. I'm sure there was a bill on -- for the
15 May 31st, but I must admit I don't know what it is.

16 Q. All right. Now, was this done through the
17 auspices of the hospital, or is this a business
18 that's handled on the side or...

19 A. This is a side business.

20 Q. All right. And you had not seen the
21 plaintiff, Mr. Bliss, before this visit on May 31st?

22 A. Correct.

23 Q. And you haven't seen him since?

24 A. Correct.

25 Q. And the only information that you would

Page 34

1 have had regarding his past medical history or any
2 history after you saw him would have been provided
3 by his lawyer?

4 A. Yes. The box of records, yes.

5 Q. Right. I mean, you haven't consulted with
6 any of his treating physicians, you haven't -- in
7 other words, not being a health-care provider for
8 Mr. Bliss, you're not in the loop discussing
9 treatment plans or anything like that?

10 A. That is correct, I am not.

11 Q. Now, you refer in your report to your
12 physical examination as a neuro-musculoskeletal exam
13 focused on his lumbar spine and his lower
14 extremities; is that right?

15 A. That is right.

16 Q. In terms of the interview that you had
17 with Mr. Bliss, I take it that you're -- the only
18 basis that you had as reflected in your report in
19 terms of the -- his background with the railroad or
20 the circumstances of the incident on February of
21 2011 would have been based solely on that
22 information provided to you by Mr. Bliss?

23 A. Correct.

24 I suppose I should add the caveat, and I
25 have the medical records, but Mr. Bliss re- -- that

Page 35

1 reported to me.

2 Q. Right.

3 I noticed also, Doctor, we obtained copies
4 of everything that was provided to you through a
5 request to counsel for Mr. Bliss, and in the
6 materials were included a number of photographs. Do
7 you recall seeing photographs like this in the
8 materials that you would have received?

9 A. Yes, I do recall.

10 (Exhibit No. 82
11 marked for identification.)

12 BY MR. SATTTLER:

13 Q. For the record, I've asked, and the court
14 reporter has marked as Exhibit 82, a series of four
15 photographs. Also for the record these are Bates
16 marked DID000759, -760, -761 and -762.

17 Doctor, if you could take a look at those
18 photographs.

19 With respect to those four photos in
20 Exhibit 82, do those look like the photos that were
21 provided to you by counsel?

22 A. Yes, they're the same.

23 Q. Okay. I note in your report you said, "I
24 reviewed photos of the device and how it works."

25 You were talking about this hydraulic ram?

Page 36

1 A. Exactly.

2 Q. What you left off in your testimony, which
3 appears in your report, is that it is maneuvered
4 into place. And I want to make sure that you
5 recognize that -- or accept that the photos here in
6 Exhibit 82 -- was it your understanding that this
7 was how it was maneuvered by Mr. Bliss at the time
8 of the accident?

9 A. Yes.

10 Q. Okay. And you've had a chance to look at
11 those? All right.

12 So these four photographs showing him
13 leaning over, grabbing the device and maneuvering
14 it, you understood that that was taking place on the
15 date of the incident?

16 A. Correct.

17 Q. And that formed, at least in part, the
18 basis for your opinions here today?

19 A. Yes.

20 Q. Now, interestingly, you note in your
21 report that the episode occurred when he simply, as
22 he stood up, something popped in his low back. Do
23 you recall putting that in your report?

24 A. Yes, that's what he reported to me.

25 Q. Right. And for those of us who are not

Page 37

1 physics majors, I'm going to use a term, but I'd
2 like you to explain it to the jury. One can load
3 the spine --

4 A. Correct.

5 Q. -- by lifting heavy objects or maneuvering
6 heavy objects, et cetera.

7 Can you explain what the difference is
8 between just standing up versus moving with some
9 type of a heavy object in terms of loading of the
10 spine?

11 A. Yeah. I'm not sure that I can.

12 Q. Okay.

13 A. But this -- the spine, as I have been
14 demonstrating, is a series of bony blocks separated
15 by cushions or -- that we call discs. And certainly
16 going from a bent-over position to standing back up
17 changes forces across the spine.

18 And as a physician, of course, I'm -- I
19 start with what the patient tells me, and he says --
20 he reports, simply, as he stood up, something popped
21 in his low back, which is -- it was actually not an
22 unusual report.

23 Q. There are reports of people who just bend
24 over to pick up the newspaper --

25 A. Exactly,

Page 38

1 Q. -- and will have a disc problem, right?

2 A. Right. Or sneeze.

3 Q. Actually, if you look back at Dr. Noble's
4 operative report -- or the reports around the time
5 that he had the first discectomy, this is the one
6 back in 2010, I think it's in May of 2010, you
7 report the patient telling you that he was picking
8 up a bucket of water for his dog.

9 You'll note in Noble's report, he got a
10 history of just bending over to pick up a sock; do
11 you remember that?

12 A. I didn't discover that.

13 Q. Okay.

14 A. Perhaps Dr. Noble was confused.

15 Q. Well, either that or the history has
16 changed, right?

17 A. Yeah, or I'm -- or my report's confused.
18 I'd be happy to look at that, if I can...

19 Q. Do you have the operative report from the
20 May incident -- or the May surgery, I should say?

21 A. Yes, I do.

22 Q. Okay.

23 A. I have it.

24 Q. I've got one from -- and for the record,
25 this is Bates marked NSC00020. This is from Noble's

Page 39

1 spine center.

2 He says, "He bent over to pick up a
3 socks -- a sock, when he felt a pop and felt a sharp
4 stabbing in the left side of his low back and into
5 his buttocks."

6 A. So that's different than what I learned.

7 Q. Right.

8 What I'm more interested in, rather than
9 the disparity in the history, is the fact that
10 events to the spine can occur as a result of just
11 fairly minimal movement of the body; isn't that
12 correct?

13 A. That's true.

14 Q. Now, I want to talk a little bit about
15 your referral to this situation as a "failed back
16 syndrome."

17 Now, this failed back syndrome is
18 terminology that's used in your field. It's a term
19 of art used in your field, is it not?

20 A. That's true.

21 Q. And it refers to chronic pain experienced
22 after unsuccessful surgery for back pain; isn't that
23 how it's typically defined?

24 A. That's very good, yes.

25 Q. Now, surgery for back pain is conducted

Page 40

1 when there is an identifiable source of the pain,
2 and I think you actually used language in your
3 direct examination that the best attempts at fixing
4 the problem through surgery were made and that there
5 were appropriate indications for the surgery when
6 the surgeries occurred. I think that's the language
7 you used.

8 A. Correct.

9 Q. But back pain can also have a number of
10 causes, and accurate identification of a source of
11 pain is complicated. And I notice when you also
12 gave your testimony about the failed back syndrome,
13 I think you used the term he had "ongoing irritation
14 over one or more of the nerve roots of the spine."
15 I think that's the language you used.

16 A. Yeah. I think I -- toward the end --
17 counsel asked me why -- what was the source of -- of
18 his continued complaints of pain, and based on
19 Mr. Bliss's description of his pain and my findings
20 at the time of my physical exam, it would suggest
21 that he has ongoing problems or something causing
22 pinched nerves.

23 Q. Right. And you're using the term plural,
24 "nerves."

25 You're talking about -- he's got a -- when

Page 41

1 we talk about a failed back syndrome, the real issue
2 is trying to figure out where the pain source is,
3 right?

4 A. That's true.

5 Q. And the difficulty is that when you try
6 all these surgical approaches, you do the best you
7 can, based upon the diagnostic tools that you
8 typically would use, like MRIs, discography,
9 whatever it might be, to isolate an area that may be
10 the pain generator?

11 A. That's correct.

12 Q. But when you're in a failed back syndrome
13 situation, what you have is a number of different
14 levels that are deteriorating over time -- and by
15 the way, this gentleman has degenerative disc
16 disease; does he not?

17 A. That's correct.

18 Q. That's a progressive disease that's been
19 ongoing for many years?

20 A. It can be a progressive disease.

21 Q. Have you compared his MRI studies from the
22 2010 time frame to the more recent ones?

23 A. I have not seen those.

24 Q. And then, of course, the symptoms that
25 we're talking about, when we talk about complaints

Page 42

1 of pain, that's a subjective symptom, right?

2 A. That is correct.

3 Q. And while we have these diagnostic tools
4 to try to find out objectively where the pain
5 generator is, it doesn't always work out that way?

6 A. That is true.

7 Q. Okay. Now, causes of failed back
8 syndrome, um, that can be the original cause of
9 pain, in terms of recurrence, it can even be
10 complications that occur during surgery; isn't that
11 true?

12 A. Correct.

13 Q. And when the surgery occurs, a nerve root
14 causing the pain can be inadequately decompressed,
15 right?

16 A. Correct.

17 Q. Joints or nerves may become irritated
18 actually during the surgical procedure itself?

19 A. Correct.

20 Q. Scar tissue can form and cause recurring
21 pain?

22 A. Correct.

23 Q. And also inadequate or incomplete
24 rehabilitation or physical therapy, especially in
25 patients whose back muscles are deconditioned, can

Page 43

1 cause chronic pain?

2 A. Correct.

3 Q. Now, there was a point at which during
4 direct examination you were reading from your
5 report, and I'm assuming that was just the -- to
6 refresh your memory as to your exam and your
7 analysis.

8 But, um, this testimony that you gave
9 about Mr. Bliss having pain radiating into his heel
10 and associated with numbness over the lateral aspect
11 of his foot, that was by his report to you?

12 A. Correct.

13 Q. Now, on your examination -- and again, I
14 take it that this examination that you conducted,
15 Dr. McGuire, is in the context of doing what you
16 were asked to do, which was essentially put together
17 an impairment rating for this guy?

18 A. Correct.

19 Q. Now, you understand we're not in a
20 workers' compensation setting?

21 A. Correct.

22 Q. You also understand, and I think you
23 actually testified, that when we talk about
24 impairment, we're not -- that doesn't equate with
25 disability under the AMA guides; that's a distinct

Page 44

1 issue?

2 A. That is correct.

3 Q. Now, I want to talk a little bit about the
4 approach that a physician in your position would
5 take. Doing a rating under the AMA guides, and the
6 type of physical examination that you would
7 undertake -- and as a matter of fact, the AMA guides
8 actually list and identify the type of physical
9 examination for lumbar spine rating under the
10 guides.

11 A. Correct.

12 Q. They talk about a standing position
13 examination for posture, palpation, gait, range of
14 motion, muscle strength screening. They talk about
15 a sitting position, with neurological and nerve
16 tension testing. These are all kind of a guideline
17 under the AMA guides for how you do the lumbar exam,
18 right?

19 A. Correct.

20 Q. Now, in looking at the -- at your report,
21 you did a physical -- or excuse me, a visual
22 examination of the lumbar spine, correct?

23 A. Correct.

24 Q. There's no mention here in terms of these
25 various positions that one might have a patient

Page 45

Page 47

1 in --
 2 A. Well, I --
 3 Q. -- like, recumbent supine, recumbent
 4 prone, sitting position, or the exam's in a standing
 5 position?
 6 A. I guess I could fill that in for you.
 7 Q. Well, but it's not reported here is the
 8 point.
 9 A. I can tell you that he was standing during
 10 the visual examination of the lumbosacral spine.
 11 Q. All right. And there's no mention of
 12 posture in your report?
 13 A. Well, that's not true.
 14 On the first sentence of my paragraph of
 15 the report, I note that he moved about the office in
 16 a satisfactory fashion, and that -- that reflects
 17 his posture.
 18 Q. Okay. There's no negative note regarding
 19 his posture?
 20 A. Correct.
 21 Q. In other words, there's no issue of
 22 lordosis, kyphosis, nothing like that?
 23 A. Correct.
 24 Q. So his posture was normal?
 25 A. Correct.

Page 46

1 Q. All right. Now, in terms of palpation of
 2 the spine, no mention of that?
 3 A. Correct.
 4 Q. Now, you didn't check for muscle spasm,
 5 guarding?
 6 A. No.
 7 Q. But if he had normal posture, that would
 8 tend to suggest that he didn't have muscle spasm or
 9 guarding?
 10 A. Correct.
 11 Q. Now, what is the significance of that in
 12 terms of the Ladies and Gentlemen of the Jury, the
 13 fact that there isn't a change in the posture caused
 14 by muscle spasm or guarding?
 15 A. Well, you note that at the beginning, in
 16 my opening paragraph, I state that I performed a
 17 neuro-musculoskeletal exam, and you are making
 18 reference at this moment to muscle function -- or
 19 muscle findings.
 20 Q. Well, but that's only because we're
 21 looking at the AMA guides as to how you do the
 22 impairment rating for the lumbar spine.
 23 A. Right. And I'm not suggesting that there
 24 are any muscle problems.
 25 Q. Okay. But what I to make sure is is --

1 let me ask you a different way.
 2 Did you follow the AMA guides in terms of
 3 your physical examination?
 4 A. I used a combination of my training,
 5 experience, and the Table 15-3 in the -- in the
 6 guides.
 7 Q. Well, the Table 15-3 is just punching up
 8 the numbers. It's not the physical exam
 9 recommendations made by the AMA?
 10 A. No. I do my physical exam.
 11 Q. So you didn't follow those recommended?
 12 A. Well, actually I did, but perhaps not the
 13 way you hoped I had.
 14 Q. Okay. But in terms of posture, in terms
 15 of gait, range of motion, and whatever muscle
 16 strength screening that you did, there was nothing
 17 out of the ordinary?
 18 A. Correct.
 19 Q. All right.
 20 VIDEOGRAPHER: Counsel, we are off
 21 the record.
 22 The time is 1:39 p.m.
 23 (1:39 p.m. - Recess taken.)
 24
 25

Page 48

1 (At 1:42 p.m., with parties present
 2 as before, the following proceedings were had,
 3 to-wit:)
 4 VIDEOGRAPHER: Please stand by.
 5 Counsel, we are back on the record.
 6 The time is 1:42 p.m.
 7 BY MR. SATTTLER:
 8 Q. Doctor, when we broke, we were going over
 9 your physical examination of the plaintiff,
 10 Mr. Bliss, and I was going through the AMA guides in
 11 terms of the physical exam for the lumbar spine. We
 12 had just talked a little bit about this muscle
 13 issue.
 14 Did you do any measurements of his lower
 15 extremities to determine if there was any atrophy of
 16 his lower extremity?
 17 A. No, I did not.
 18 Q. You didn't find any objective signs of
 19 loss of motor function or loss of innervation to the
 20 muscles?
 21 A. No, I did not.
 22 Q. Are you aware of whether or not at any
 23 time anyone has done any electromyographic
 24 diagnostic studies on this radiculopathy that has
 25 been discussed here today?

Page 49

Page 51

1 A. Not by memory. I guess I could not
2 guarantee that there is or is not a report in that
3 box.

4 Q. You didn't rely on any EMG studies --

5 A. No.

6 Q. -- or any other electrodiagnostic studies
7 to come up with some objective evidence of the basis
8 for the radiculopathy complaints?

9 A. No, I did not.

10 Q. Let's talk about this pain-free passive
11 full range of motion of both hips and knees.

12 Could you describe for the jury what
13 passive range of motion is, and what you're really
14 looking at in terms of range of motion as it relates
15 to the hips and knees?

16 A. Yes. So in this part of the exam, the
17 patient is seated on an examining table. And, um,
18 if -- we're trying to learn or rule out another
19 cause for pain through the extremity. And certainly
20 an arthritic hip and/or arthritic knee can cause
21 radicular pain through the extremity.

22 In Mr. Bliss's part, I was able to
23 demonstrate a full range of motion. And by passive,
24 it means that the examiner is moving the joint
25 rather than the -- in an active sense, the patient

Page 50

1 is moving.

2 So to my movement of the extremity, to
3 stimulate a range of motion, both of his hips and
4 both of his knees, that was all done without causing
5 any pain. Essentially, in a 56-year-old male,
6 ruling out arthritis of the joint as a possible
7 cause.

8 Q. All right. With respect to range of
9 motion of the spine, can you test that? Can you
10 measure it?

11 A. Yes, you can.

12 Q. Did you do that?

13 A. Well, I noted that he was able to
14 partially disrobe for the exam without difficulty.
15 That required some bending and twisting and moving,
16 but I did not -- I did not list any direct
17 measurements.

18 Q. There's actually a device called -- what
19 is it, an inclinometer?

20 A. Yeah. I don't use that.

21 Q. And you understand the AMA guides, the
22 difference between the approach you took for
23 measuring impairment on the lumbar spine, there's
24 another one where they use range of motion, right?

25 A. Yes.

1 Q. And you didn't use that methodology?

2 A. That is correct.

3 Q. Now, in terms of reflexes, you did note
4 that reflexes were absent in the left lower
5 extremity, and could not be elicited, even with
6 provocation. "With provocation," we're talking
7 about what, the little hammer, the mallet?

8 A. No.

9 Q. What are you talking about?

10 A. I was hoping you'd ask me.

11 The -- as it turns out, many of us,
12 perhaps around this table, our reflexes would not
13 fire even just with a tap of a hammer. But if
14 patients are asked to grab their fingers like this
15 (indicating), it kind of sets everything, and then
16 the reflexes fire with a tap of a hammer.

17 So what I noted then in the right lower
18 extremity, the reflexes were two-plus over four with
19 this provocation. And by that, I mean they were
20 normal.

21 On the left lower extremity, I could not
22 elicit -- get any of the -- you know, you think of
23 kick the leg out, excuse me, even with the -- this
24 act of provocation.

25 Q. But you did note that the function of this

Page 52

1 hallucis longus muscle and the tendon of each great
2 toe was intact --

3 A. Yes.

4 Q. -- brisk and strong.

5 Now, in terms of radicular syndrome and
6 the nerve roots, this extensor hallucis longus is
7 related to lumbar disc level L4-5, right?

8 A. Correct.

9 Q. And that's the L5 nerve root?

10 A. Yes.

11 Q. And that was based on your -- your testing
12 here would seem to be unimpaired?

13 A. Correct.

14 Q. Was any of your other findings on physical
15 exam consistent with a specific -- or involvement of
16 a specific nerve root?

17 A. Well, actually, yes, because the -- on the
18 right lower -- excuse me. On the left lower exam --
19 left lower extremity, the absence of an ankle jerk
20 is -- makes reference to the S1 nerve root.

21 Q. That's the ankle plantar flexors?

22 A. Correct.

23 And the absence of a knee jerk is more
24 proximal, either the 3rd or 4th lumbar.

25 Q. So we're talking about involvement high --

Page 53

1 relatively high in the spine and relatively low in
2 the spine?

3 A. Correct.

4 Q. Okay.

5 A. Well, I suppose -- I don't know if -- I
6 mean --

7 Q. Well, at 3-4 or L5, S1?

8 A. Yeah, of the lumbar spine.

9 Q. Yeah, we're just talking lumbar spine?

10 A. Correct.

11 Q. But as you mentioned, that's five
12 different levels?

13 A. Correct.

14 Q. Now, you did mention this in your report,
15 the fact that Mr. Bliss had preexisting lumbosacral
16 spine degenerative disease. Can you describe for
17 the jury what that is.

18 A. Well, he's a 56-year-old male, who in
19 February of 2003, underwent surgery at the L5, S1 --

20 Q. It wasn't in February -- or February of
21 2003?

22 A. Correct.

23 Q. Okay. I'm with you.

24 A. At least on this op report.

25 Q. I'm with you.

Page 54

1 A. All right.

2 So if we look at his op report from
3 April of 2011, Dr. Noble was good enough to list as
4 No. 4 diagnosis, "Status post right side L5-S1 micro
5 discectomy, 2003."

6 So we know that for eight years prior to
7 February of 2011, he's had an absence of at least
8 part of the disc -- the cushioning between the fifth
9 lumbar and first sacro segment, and that that can be
10 connected. I don't know if it's absolutely so, but
11 it certainly can be connected to the fact that his
12 ankle jerk, deep tendon reflex, no longer works.

13 And then, as we know in 2010, he then went
14 on -- a discectomy at the L3, L4 level. So again,
15 he's had absence of normal cushioning effect.

16 And then he happens to be overweight, and
17 he's worked for the railroad for 22 years, or
18 whatever that means, and his spine is kind of
19 wearing out.

20 Q. Okay. Also, if you're on the operative
21 report for April 6 of 2011, I'm looking at the
22 St. Elizabeth Regional Medical Center operative
23 report for Dr. Noble, the surgery of --

24 A. Correct.

25 Q. Okay. I note in your -- in your report,

Page 55

1 you say the diagnosis of a recurrent disc extrusion
2 at the left side of the L3, L4 level was
3 established.

4 Actually, Dr. Noble indicates that after
5 the May 6, 2010, micro discectomy, he was advised to
6 achieve more optimal body weight to decrease stress
7 on the spine, as well as to help reduce his chance
8 of recurrent herniation. Unfortunately, he was
9 unable to lose any weight; and somewhat predictably,
10 he is back as a result of recurrent herniation.

11 A. I see that.

12 Q. Okay. Is that generally consistent with
13 the experience you've had over time?

14 A. Well, I know that I've not been able to
15 lose any weight since 2010.

16 Q. Let's talk about your patients.

17 A. Well, I see. I thought perhaps you were
18 being critical of me.

19 Well, you know, I mean, people -- I don't
20 know the numbers, but obesity contributes to -- to
21 low back problems, yeah.

22 Q. Now, finally, Doctor, in terms of what
23 we're really referring to under these -- under the
24 AMA guides, and this analysis that you undertook for
25 the impairment rating -- by the way, before we move

Page 56

1 off of that, I want to just tie up what I left off
2 on the physical examination.

3 There was no evidence of -- of any loss of
4 bowel or bladder with Mr. Bliss?

5 A. That is correct.

6 Q. Any function.

7 So we -- in terms of other sensory loss,
8 other than his report, did you test for any sensory
9 loss?

10 A. No, I did not.

11 Q. Now, going back to the AMA guides in terms
12 of the impairment, this refers to a loss or decline
13 of functional capacity as a result of a medical
14 condition or a symptom, right?

15 A. Correct.

16 Q. Whereas a limitation is something that an
17 individual cannot perform due to a medical
18 condition. These limitations can be objectively
19 measured, and tests have been devised to assess
20 these limits of physical capacities. And I think
21 the jury is going to hear about functional capacity
22 evaluations. All right?

23 A. Okay.

24 Q. Now, a restriction is not what a patient
25 cannot do it, it's what a patient should not do

Page 57

1 because there is a substantial or immediate risk of
2 harm to him or others, correct?

3 A. Correct.

4 Q. Now, with respect to this impairment
5 rating that you've arrived at in this case, these
6 guides from the AMA attempt to standardize an
7 objective approach to evaluating medical impairments
8 focused on perceived interference with activities of
9 daily living.

10 I think you referred -- without using that
11 terminology, I think you referred to these -- our
12 normal activities in life?

13 A. Correct.

14 Q. Right. But again, the guide offers that
15 just because a person may be assessed with an
16 impairment that may interfere with these activities
17 of daily living, there may be no corresponding
18 diminution and ability to perform productive work?

19 A. Correct. In fact, I used myself as an
20 example.

21 Q. As an example.

22 Determining whether a patient is impaired
23 is a medical opinion, whereas whether or not someone
24 is actually disabled is not a medical opinion?

25 A. That is correct.

Page 58

1 Q. And the medical role is to determine
2 functional limitations or medically reasonable
3 restrictions, and not to make occupational
4 determinations?

5 A. I'm sorry, say that again?

6 Q. The medical rule, your role --

7 A. Yes.

8 Q. -- is to determine functional limitations
9 or medically reasonable restrictions and not to make
10 occupational determinations?

11 A. That is correct.

12 Q. And you've not had any specific training
13 in making occupational determinations?

14 A. That is correct.

15 Q. And the only information that you had
16 available to you as to what he did at the BNSF
17 Railway time -- at the BNSF Railway was his
18 description of him maneuvering this -- this
19 hydraulic jack, as depicted in these photographs in
20 Exhibit 82, for a two- or three-hour period?

21 A. Correct.

22 Q. That's the only thing you know about his
23 job?

24 A. I think that's fair.

25 Q. Okay.

Page 59

1 MR. SATTLER: I think those are all
2 the questions I have, Dr. McGuire. Thank you.

3 MR. MCMAHON: I have nothing. Thank
4 you, Doctor.

5 VIDEOGRAPHER: Counsel, we are off
6 the record.

7 The time is 1:56 p.m.

8 (1:56 p.m. - Recess taken.)
9

Page 60

1 CERTIFICATE

2 STATE OF NEBRASKA)

) ss.

3 COUNTY OF DOUGLAS)

4 I, Gretchen Thomas, Registered
5 Professional Reporter, General Notary Public within
6 and for the State of Nebraska, do hereby certify
7 that the foregoing testimony of Michael McGuire,
8 M.D., was taken by me in shorthand and thereafter
9 reduced to typewriting by use of Computer-Aided
10 Transcription, and the foregoing fifty-nine (59)
11 pages contain a full, true and correct transcription
12 of all the testimony of said witness, to the best of
13 my ability;

14 That I am not a kin or in any way
15 associated with any of the parties to said cause of
16 action, or their counsel, and that I am not
17 interested in the event thereof.

18 IN WITNESS WHEREOF, I hereunto affix my
19 signature and seal this 1st day of July, 2013.
20

21
22 GRETCHEN THOMAS, CCR, RPR, CRR
23 GENERAL NOTARY PUBLIC
24 Certified Court Reporter
25 Registered Professional Reporter
Certified Realtime Reporter

My Commission Expires: